Ministry of
JUSTICE

Report of the Inquiry into the circumstances of the Death of Bernard (Sonny) Lodge at Manchester Prison on 28 August 1998

December 2009

HC 127

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FOREWORD

Sonny Lodge died by his own hand in the segregation unit of Manchester prison on 28 August 1998. He had been due for release that day, from a five month sentence, but remained in prison remanded on a charge of assaulting a prison officer.

The purpose of the inquiry was to examine the care of Mr Lodge by the Prison Service in the period leading to his death, in order to identify any deficiencies that may have had an influence on his death, and to help prevent similar tragedies.

During his sentence, there were two critical incidents when Mr Lodge was accused of assaulting or attempting to assault prison officers. Both incidents were contentious and reflected poor practice by certain members of staff. The inquiry discovered that prison managers had cause for concern about the good faith of an officer whom Mr Lodge was said to have assaulted. The concerns about the officer were not disclosed to the police who charged Mr Lodge with assault.

The inquiry found instances of care and concern for Sonny Lodge and some acts of kindness. Sonny Lodge could be truculent, but people who sat down with him and listened found him pleasant and cooperative. When Mr Lodge started his sentence it was known that he had self-harmed in the past and a self-harm prevention plan was adopted. After two weeks Mr Lodge assured the staff he had no problems and the plan was closed. The next day he cut his arms with a razor blade. The alleged assault on an officer occurred at an outside hospital where Mr Lodge was taken for treatment. On his return to prison a new self-harm prevention plan was opened. It was closed three weeks later. After that, staff assessed Mr Lodge's state of mind, and made decisions about his care, without knowing the history.

A few days after the self-harm prevention plan was closed, Mr Lodge committed a disciplinary offence. The punishment meant he spent the next week on a restricted regime, with no association periods, tobacco, radio, publications or any other means of occupation or distraction. It was an unusually stringent punishment. At the end of the week, he was supposed to be going back to E wing where he could have resumed employment. Instead he spent three weeks on K wing.

Reports from HM Prisons Inspectorate show that K wing was a grim place in 1998. It had small cells designed for one prisoner but occupied by two, with unscreened toilets.[1] For most K wing prisoners there was no work or education. Men spent long hours locked up, or out on the landings with no structured occupation, watched from a distance by staff who were often wary and hostile. Sonny Lodge wrote that being on K wing was *"doing his head in".* It was not a healthy environment for a young man who had recently self-harmed; a young man who, his sister said, *"needed help more than punishment".*

Sonny Lodge believed he was victimised for the alleged assault on a prison officer. The inquiry found no evidence of any concerted victimisation but some foundation for his sense of injustice. In the last week of Mr Lodge's life, when he learned he would not be released, his girlfriend was alarmed about his state of mind and telephoned the prison. A series of people who did not know Sonny Lodge talked to him. Each decided he was not going to harm himself. Each made their judgment in good faith but information was not brought together. If it had been, Mr Lodge might have been protected.

The day before Mr Lodge died, he had two altercations with members of staff. He was charged with attempted assault and placed in cellular confinement by a governor who did not know about his history of self-harm or about his girlfriend's warnings.

The prison sentence he received in 1998 might have been a turning point for good in Sonny Lodge's life. He had a poor start in life and a 14 year drug habit but, at the age of 28, he had an important relationship, a new home to go to with his girlfriend, and sisters who cared about him. He was sensitive to his failings as a father and was able to imagine a different kind of life. Prison meant enforced withdrawal from drugs. It might have been a chance to turn his life around. It would have been an uphill struggle, and he needed all the help he could get.

Mr Lodge was one of many short sentence prisoners. Like many other short sentence prisoners he had complex needs. Doctors said he needed psychiatric follow-up, counselling and support to stay off drugs. None of this was provided. If short spells in prison for relatively minor offenders are to have any reformative value they should be focussed from day one on preparing for release. That means engaging with prisoners as individuals, helping with practical problems, supporting family links, putting in place support to help them stay off drugs, providing appropriate mental health care, and

[1] Double occupancy remains the norm. The toilets now have a privacy curtain.

improving social skills and skills for employment. It does not mean isolation, idleness and hostile authority.

Nor does it mean *"keeping your head down"*, as prisoners are often urged to do, if that means not drawing attention to yourself and not bothering the staff. Prison officers who know how to talk to prisoners appropriately can have a profound influence. Constructive engagement between staff and prisoners can save lives. By contrast, lack of fairness and respect increases prisoners' distress.

Much has changed for the better since 1998 in the policies and procedures of Manchester prison and the Prison Service generally. It is beyond the scope of the inquiry to say how successfully these changes operate in practice, but there is no doubt that the Prison Service has shown a strong commitment to learning from past tragedies. It has invested substantial resources in new strategies for preventing suicide and self-harm. The current policy seeks to reduce risk by *"ensuring all prisoners (whether identified at risk or not) receive individual support in managing any problems".* Among the goals of the policy is *"reduction in distress and improved quality of life for all who live and work in prisons".* From the evidence to this inquiry, that was not the ethos in significant parts of Manchester prison in 1998.

What is the benefit of an inquiry of this kind, over a decade after Mr Lodge's death? I am conscious of the costs, the time and energy diverted from present services, and the emotional demands placed upon everyone who had some personal involvement. Counsel for the family told the inquiry their aims were uncovering the truth, securing accountability for Mr Lodge's death, and preventing future tragedies where possible. Through Sonny Lodge's letters, and the evidence of those the inquiry spoke to, we have seen something of what it felt like for a troubled young man to be a prisoner at Manchester in 1998. We have learned how the face he put on for people he did not know or trust did not tell the whole story, how he responded differently to people according to how they treated him, and how casual mistreatment – by systems or people – can breed despair.

Looking back over more than ten years, I must not present a sentimental view of Sonny Lodge because of the tragic manner of his death. But recounting his personal experience shows – if it were not already clear – that the basis of decent prisons is the principle that prisoners are complex individuals who deserve to be treated with humanity and respect.

The report makes 48 findings but only 9 specific recommendations. Those who work in prisons are best placed to devise operational responses. Much has changed since 1998 but I hope that prison managers will still find many lessons in the report. The main one is that a healthy prison culture, in which staff engage with prisoners as individuals and have the will and the resources to help them with problems, is the best defence against prisoners' desperation and despair.

Barbara Stow
Chair of the Inquiry

NOTE ON THE STRUCTURE OF THE REPORT

Part One contains a summary of the events that are examined in detail later. It explains what led to the inquiry and why it took place so long after Sonny Lodge's death. The process of the inquiry is described and I make some observations about procedure in inquiries of this kind.

Part Two examines the events in detail and sets out the principal evidence that forms the basis of the inquiry's findings.

Part Three contains the inquiry's consideration of the evidence, the findings and some recommendations. It contains some evidence that is not in the narrative in earlier chapters. This includes advice from the clinical adviser to the inquiry, information about Prison Service policies and procedures and changes at Manchester Prison, reference to research findings, and some observations that witnesses made in evidence to the inquiry.

Part Four lists the findings, recommendations and observations about procedure.

Annex 1 contains the inquiry's Terms of Reference.

Annex 2 is a note on the procedure the inquiry followed

The terms of reference and the procedure were adopted before the investigation was converted to a statutory inquiry. The inquiry departed from them where required to do so to comply with the Inquiries Act 2005 and the Inquiry Rules 2006.

Annex 3 lists the legal representatives.

Annex 4 is a glossary of acronyms and references.

CONTENTS

PART ONE

WHAT LED TO THE INQUIRY

This part of the report contains a summary of the events that are examined in detail later. It explains what led to the inquiry and why it took place so long after Sonny Lodge's death. The process of the inquiry is described and I make some observations about procedure in inquiries of this kind.

The terms of reference of the inquiry are attached to the report at Annex 1. A note on the investigation procedure is at Annex 2.

I have tried to avoid, as far as possible, the use of acronyms, which can be confusing to readers who are not familiar with them, but sometimes it would be too cumbersome to use common terms in full each time they occur. There is a glossary of acronyms and references at Annex 4.

Chapter 1

SONNY LODGE AND AN OUTLINE OF THE EVENTS WHEN HE WAS IN PRISON

Summary

1.1 This chapter introduces Sonny Lodge[1] and gives an outline of the events that are examined in detail later in the report.

Sonny Lodge

1.2 Bernard Joseph Lodge was born in Manchester on 6 August 1970. When he died in Manchester prison on Saturday 28 August 1998, he was 28 years old. Bernard was known in the family as Sonny. When he was two, Sonny and his two sisters were placed in an orphanage in Dublin. Boys and girls were separated and Sonny rarely saw his sisters. When Sonny was seven, their mother returned and took the children to live in Manchester. Sonny's sister says their mother's partner had a bad temper and often hit Sonny. Their natural father died in 1982 and their mother in 1991.

1.3 At the age of 17, Sonny became father to a daughter. His son was born the following year. From 1986 to 1992 Sonny lived with his children and their mother. Sonny was using hard drugs and their mother was concerned for the children. Sonny left the family home but remained in touch with the children and their mother.

1.4 In a prison record, Sonny's occupation was recorded as being a joiner and a friend said that in 1998 he worked in a garage for a time; but, from December 1986 to October 1997, he incurred 22 convictions, mainly for small-scale property offences or breach of court orders. There was one offence of violence, causing actual bodily harm, in 1986. Sonny served short prison sentences in 1994 and 1996. On 15 June 1998, he was sent to Risley prison on a sentence of five months for shoplifting and breach of bail. He was due to be released from prison on licence on 28 August.

1.5 Sonny's family say his convictions were related to his drug dependence. When Sonny arrived at Risley in June 1998, he had a longstanding heroin habit, and smoked

[1] I have thought carefully about what to call Sonny Lodge in this report. To call him Sonny risks suggesting a familiar relationship that the inquiry should not claim, or treating this 28 year old man as a child not responsible for his actions. But to say Mr Lodge sometimes seems artificial and too formal and distant for the person at the heart of this inquiry. Bernard was his given name but he was not generally known by it. I considered using initials as being a neutral form but that seemed too impersonal. Sonny Lodge was known differently by different people. I have decided mainly to use the names Sonny or Sonny Lodge by which he was known to friends and family. I hope that this will not offend any of the people reading this report and that it will not be misinterpreted as bias.

30 cigarettes a day. His medical records show various attempts to overcome addiction to heroin and amphetamines but his attendance at clinics was unreliable and his treatment programmes lapsed.

1.6 Sonny's sisters knew him as a beloved brother and affectionate uncle who adopted a happy go lucky front and acted younger than his years, whose life was blighted by his addiction and who needed help more than punishment.

1.7 Sylvia O'Reilly said of her brother:

"Sonny wasn't a violent person. He was never violent. … he would get very upset and very low but it was basically because of himself and the person he was and he was never aggressive. He would never pick a fight with anybody. He wasn't like that. … his disappointments in life were his own disappointments in life … he'd get upset about it… he'd cry, and we'd discuss it but he never got aggressive.

"He wasn't an aggressive, violent person… He was a 28-year-old supposedly 'man', who was more like a child, in a lot of ways… that had drug problems.

"He had two children that he really loved but he couldn't get his head round looking after his children properly. …it hurts me to think that there could be anyone out there just imagining him to be something that he wasn't. … He was a massive Disney fan. He needed help, that's all he needed - help, not punishment; help.

"Sonny wasn't a bad person. He was a petty criminal with a drug habit who needed help more than anything."

Risley prison

1.8 Sonny Lodge was admitted to Risley prison on 15 June 1998. He was given medication for withdrawal from drugs. A health care officer opened a self-harm prevention plan (called a form F2052SH) because Sonny had self-harmed at Risley a year earlier and told the officer he might harm himself.

1.9 The F2052SH was closed at Risley on 25 June. On 26 June Sonny cut his arms with a razor blade and was taken to hospital. He spent the night in Warrington Hospital and was then taken to Whiston Hospital for treatment. An incident occurred there and Sonny Lodge was later charged with inflicting grievous bodily harm on one of the escorting officers. This was why he was in prison on the day he died. The circumstances of the incident are contentious and the inquiry has examined it in detail. Sonny Lodge

denied the charge. He admitted pushing the officer, but claimed it was in response to an assault upon him. The evidence was not tested in court because of Sonny Lodge's death. Information came to light in the inquiry about the disciplinary history of the officer involved.

Garth prison

1.10 Sonny Lodge was assessed by a psychiatrist at Warrington hospital who recommended further psychiatric assessment and medication.

1.11 From hospital, Sonny was discharged to the healthcare wing at Garth prison. An officer in the healthcare centre opened a new F2052SH. A nursing care plan was devised aiming to relieve depression and risk of self harm. Sonny saw the prison medical officer, who recommended that he needed counselling but not medication.

1.12 Sonny was charged under the Prison Rules with assaulting an officer at Whiston Hospital. A governor's adjudication was opened at Garth. The record indicates that Sonny pleaded guilty. The adjudication was adjourned as the incident was in the hands of the police. Sonny spoke privately to a governor at Garth who thought his actions might be considered self-defence. The governor was sufficiently concerned about Sonny's account to write to the Head of Residential Services at Risley.

1.13 Sonny stayed in the healthcare centre at Garth until 9 July. The medical officer's discharge report recommended that Sonny needed ongoing support and that long-term issues about drug abuse needed addressing. On 9 July Sonny attended a hospital outpatient appointment and from there was transferred to Manchester prison.

Manchester Prison

1.14 When Sonny arrived in Manchester, the F2052SH remained open. There were frequent entries in the daily supervision and support records but appeared to be no support plan. Records by a senior officer, a health care officer and the medical officer indicate that Sonny claimed to be coping well, no longer felt suicidal and wanted the file to be closed. After two days in the induction unit, Sonny was transferred to E wing on 11 July. The F2052SH file was closed at a case review on 20 July 1998.

1.15 For the rest of his time at Manchester prison, Sonny was not on an F2052SH suicide prevention plan. The inquiry has examined the operation of the measures

intended to protect Sonny from self-harm and in particular whether a new plan ought to have been opened in what proved to be the final week of Sonny's life.

1.16 Sonny began work in the upholstery workshop but on 24 July he was sacked and charged with endangering health and safety by firing staples from a compressed air gun. At the adjudication, a governor imposed seven added days suspended for one month, seven days stoppage of 100% of earnings and seven days stoppage of all privileges. Losing his job and the temporary loss of privileges significantly altered Sonny's access to occupation and resources for the remainder of his sentence. It also prompted the first of several wing moves.

1.17 Sonny said repeatedly in letters and sometimes in person that he believed he was being victimised by prison staff in reprisal for the alleged assault at Whiston Hospital. I have quoted from his letters in the report. There is no evidence that prison staff knew the content of these letters when Sonny Lodge was in prison. The inquiry examined Sonny's belief he was being victimised, his various wing moves and the regimes on the wings. The clinical adviser to the inquiry has advised on the implications for Sonny's mental health of his belief that he was being victimised.

1.18 In particular, the inquiry examined the operation of a system of informal sanctions imposed by wing officers, without due process, for alleged misbehaviour. The usual sanction was for a prisoner to be locked up for the evening association period when he would otherwise be able to mix with other prisoners, make telephone calls and take a shower. The system was criticised by the Chief Inspector of Prisons. Sonny was locked up for the evening a number of times.

1.19 On Monday 24 August, Sonny was taken to Huyton police station where he was interviewed and charged for the alleged assault on a prison officer at Whiston Hospital. The legal executive who attended the interview says that the police came for him at Sonny's instigation because he wanted to get the charge sorted out before he was released. Forms completed by police and prison officers transferring custody of Sonny recorded that he had attempted suicide and might have suicidal tendencies.

1.20 Sonny told his girlfriend he expected to get bail but on Tuesday 25 August his solicitor told her that the police and the magistrates had refused bail and Sonny was a bit down. Sonny's girlfriend was alarmed and telephoned the prison to say she was worried that Sonny might self-harm, having done so before. A message was passed to reception

and to Sonny's wing. A health care officer in reception and later a wing officer spoke to Sonny about it. Both formed the impression there was nothing to worry about. The health care officer made a note in the medical record and the wing officer in the wing observation book.

1.21 During this week, Sonny's letters to his girlfriend became more and more desperate. Again, there is no evidence that prison staff knew the content of the letters. It is not certain how quickly his girlfriend received each letter but, early on Wednesday morning, she telephoned the prison again and asked to speak to a chaplain. The Methodist chaplain visited Sonny. She found him depressed, and aggrieved by a sense of injustice, but he did not want to make a fuss on the wing and the chaplain decided to keep her concerns within the chaplain's team. During their conversation, Sonny said he had thought about suicide but did not know how to kill himself.

1.22 Sonny wrote another letter to his girlfriend, probably during the night of Wednesday/Thursday 26/27 August. He expressed despair that he would not be going home on Friday and wrote of giving up. He felt he was being victimised.

1.23 As agreed between the chaplains, the Church Army chaplain visited Sonny on the wing in the morning of Thursday 27 August. He said Sonny's manner was morose. The chaplain said he tried to encourage Sonny to take things a step at a time.

1.24 Sonny's girlfriend visited on Thursday afternoon. During the visit, Sonny told his girlfriend prison officers were *"having a go at him again."* On the way back to the wing, there was an altercation between Sonny and an officer. He was told he would miss association that evening.

1.25 Sonny's cellmate said that when he returned from the visit Sonny was feeling low and said he was not surprised when told he was on *"bang-up"* that evening. The cellmate said he wanted to stay in the cell with Sonny during association but the officers would not let him.

1.26 Officers decided to search Sonny's cell. The inquiry has examined the reasons for the search, the procedure followed, and conflicting accounts of what happened. When Sonny returned to the cell an incident occurred. Sonny is alleged to have attempted to assault an officer. He was restrained. During the restraint he seemed to lose consciousness or experience momentary fits. He was taken to the health care

centre for examination, then to the segregation unit, where he spent the night, before a governor's adjudication the next morning.

1.27 The governor appointed to investigate the circumstances of Sonny Lodge's death asked the police to investigate the incident in the cell. The officers were interviewed under caution. The Crown Prosecution Service found there were no grounds to prosecute. As a result of an investigation in September 1999 two officers and a senior officer received *"informal warnings"* for not completing records about the cell search and the use of control and restraint. The senior officer received an additional informal warning for not ensuring that the search forms were completed. The informal warnings to the officers were later withdrawn as a result of grievance proceedings because there had been no formal disciplinary process.

In the segregation unit

1.28 A chaplain is required to visit all prisoners in the segregation unit once a day. The Roman Catholic chaplain saw Sonny Lodge early in the morning without prior knowledge of him. In statements made after Sonny's death the chaplain said Sonny told him an officer had hit him in the face, saying it was for the officer whom he allegedly assaulted at Risley. The chaplain said that he told the senior officer in charge of the unit that Sonny seemed low and fed up.

1.29 Sonny asked the chaplain to telephone his girlfriend to say he would not be discharged that day unless his application to a judge for bail was successful. The Church of England chaplain was aware that Sonny's girlfriend had spoken to the Methodist chaplain earlier in the week. He said he would telephone Sonny's girlfriend and also told the Deputy Governor that Sonny would be alleging that he had been assaulted by an officer. The Deputy Governor passed the information on to the adjudicating governor.

1.30 Before the adjudication, the medical officer saw Sonny. He assessed him as fit for adjudication and cellular confinement. He did not have access to any records and did not know of Sonny's history of self-harm. The clinical adviser to the investigation has commented on the system of assessing prisoners' fitness for adjudication and segregation. The system has changed since 1998.

1.31 The inquiry examined the conduct and outcome of the hearing. Sonny pleaded not guilty. He said the officer had lunged at him. The adjudicator adjourned the hearing for a short time to call additional witnesses. He found the charge proved. The governor

was not aware of Sonny's history of self-harm nor the concerns expressed by his girlfriend that week. He ordered four days' cellular confinement and prospective forfeiture of 14 days' remission.

1.32 The adjudicating governor told the chaplain the outcome of the hearing and that he wanted to keep Sonny away from the wing because he felt unease about apparent animosity between Sonny and the officer he was said to have assaulted. The chaplain visited Sonny twice during the day and spoke on the telephone with his girlfriend. He applied himself to practical matters on Sonny's behalf. From Sonny's conversation and demeanour he did not think he was suicidal.

Sonny Lodge's death

1.33 An officer recalled later that Sonny had been sitting normally in his cell when he did the roll check at about 4.40 pm. The evening meal was usually served from about 6 pm. Prisoners in the segregation unit were unlocked one at a time to collect their meal. On 28 August the meal was delayed by 15 to 20 minutes because of the death of a prisoner on another wing. At about 6.20 pm an officer opened Sonny's cell to find him slumped against the pipes under the window with a ligature made of bed sheets around the window bars and his neck. The officer called for assistance. The senior officer brought scissors from the office on the floor below and cut the ligature while two officers supported Sonny's weight.

1.34 A health care officer and a nurse responded to the emergency call and attended the cell with equipment. They attempted cardio-pulmonary resuscitation and requested the doctor and a 999 ambulance. The prison medical officer came from the reception area at 6.42 pm. He pronounced Sonny Lodge dead at 6.45pm.

Chapter 2: THE INQUIRY AND HOW IT WORKED

Summary

2.1 This chapter explains what led to the inquiry, why it took place so long after Sonny Lodge's death, how the inquiry worked, some problems the inquiry faced and some lessons learned in the process. I make two observations about procedure.

Article 2

2.2 Article 2 (1) of the European Convention on Human Rights states that everyone's right to life shall be protected by law. The article imposes on government a duty not only to refrain from the intentional and unlawful taking of life but also to take positive steps to protect the right to life of people under its authority.

2.3 When someone who is in the care of government dies, there is a duty to carry out an official investigation that is independent and effective. It should also be reasonably prompt. The purpose is to ensure so far as possible that the full facts are brought to light; that culpable and discreditable conduct is exposed and brought to public notice; that suspicion of deliberate wrongdoing is allayed if it is unjustified; that dangerous practices and procedures are rectified; and that those who have lost their relative may at least have the satisfaction of knowing that lessons learned from the death may save the lives of others.

What led to the inquiry?

2.4 Sonny Lodge died 11 years ago. The circumstances of his death were investigated at the time by a prison governor from a young offenders' institution in the North West prisons area. The report was not shown to Sonny Lodge's family. That would not happen now. Shortly after Mr Lodge's death, the Prison Service adopted a practice of showing any such report to the family before the inquest. Moreover, since April 2004, deaths in prison have been investigated independently by the Prisons and Probation Ombudsman.

2.5 The inquest on Mr Lodge's death took place in July 2001. The verdict was that Mr Lodge killed himself. The family applied for permission to seek judicial review of the inquest. The High Court refused the application in January 2002 on the grounds that the Coroner's decision in the case was in accordance with the law as laid down at the time.

The Court said that any failure to comply with the procedural requirements of Article 2 should be met by a different investigation complying with those requirements.

2.6 The High Court also said that the family's application raised issues similar to ones already being considered by the courts in some other cases. Therefore the application should not be reconsidered until the other cases had run their course. Related cases were decided by the House of Lords by 2004. Among other things, it was established that the English courts could not impose requirements that investigations should comply with Article 2 when considering events that happened before the Human Rights Act 1998 incorporated the European Convention into English law. As Mr Lodge died before the Act came into force on 2 October 2000, the only recourse for the family lay in an application to the European Court of Human Rights.

2.7 Instead, Mr Lodge's family asked the Prison Service to agree to set up an investigation complying with the procedural requirements of Article 2. I was approached by the Prison Service in 2005 about the possibility of conducting an independent investigation. I reviewed the documentary evidence held by the Prison Service. I met family members and their legal representatives in November 2005 to find out their concerns and objectives. With the Prison Service's agreement, I shared with the family the report and supporting evidence from the Prison Service investigation and other documents that I had obtained.

2.8 The family made submissions to the Prison Service about the scope and nature of the investigation they sought and the arrangements to meet legal costs. In 2007 broad agreement was reached between the family and the Prison Service and I was commissioned to investigate the circumstances surrounding Mr Lodge's death, in accordance with Article 2 and drawing on evidence gathered in a Prison Service investigation and additional documentary and oral evidence at my discretion.

2.9 The inquiry was commissioned initially as an *ad hoc* investigation with no statutory powers. The investigation was converted to a statutory inquiry under section 15 of the Inquiries Act 2005 on 23 February 2009.

2.10 The purpose of the inquiry was to examine the care afforded to Mr Lodge by the Prison Service in the period leading to his death, in order to identify any deficiencies that may have had an influence on his death and to help prevent future such tragedies.

The effect of delay

2.11 The history of events leading to the inquiry goes some way to explain why it took place such a long time after Mr Lodge's death. There are adverse consequences of this long delay. Mr Lodge's family have lived for 11 years with a sense that they have not heard the whole truth about the circumstances of his death. I hope that the inquiry can lay that sense to rest.

2.12 The time lapse has been difficult for witnesses, too. The inquiry has called on them to bring back to mind events that occurred in 1998. It is not an easy experience to be called to account for one's actions or judgments from so long ago; actions or judgments taken in the course of a working day - without benefit of hindsight - and that in some cases have already been the subject of repeated investigation in other procedures.

2.13 The lapse of time since Sonny Lodge's death is manifestly a problem for another reason. Truth and justice are not well served by delay. The quality of evidence based on memory of events from 11 years ago cannot be relied on to the same extent as evidence obtained shortly after the event. For that reason, the inquiry has attached much importance to evidence obtained during the investigations by the Prison Service and the Coroner that followed more closely upon Mr Lodge's death. I have had the benefit of additional statements from witnesses responding to particular questions that the inquiry wished to examine and from oral evidence from key witnesses. In considering this evidence, I have recognised that memory fades and that where witnesses' accounts of events have not always been consistent over time I have not assumed that necessarily indicates an intention to mislead.

The inquiry process

2.14 Mr Lodge's family, through his sister, Ms Sylvia O'Reilly, and the Prison Service are interested parties to the inquiry. All the evidence has been shared with them. Both have been consulted throughout on matters of procedure and their views taken into account. Both have made submissions about the form and scope of the investigation and about lines of inquiry.

2.15 Terms of reference for the investigation and procedural arrangements were adopted in January 2008 after consultation. Ten issues were identified from the initial documentary evidence. These are attached to the terms of reference and have helped

structure the inquiry's considerations. The terms of reference are attached to this report at Annex 1 and the investigation procedure at Annex 2.

2.16 Also in January 2008, I visited Manchester prison, in the company of Mr Stephen Habgood, the governor who conducted the Prison Service investigation. Mr Habgood's report and the evidence he compiled provided an invaluable background for the inquiry's work.

2.17 Witnesses were approached in February 2008 to provide written statements about matters specified by the inquiry. Witnesses were provided with copies of any previous statements they had made and related documents.

2.18 In May 2008 I met the interested parties and their representatives and the solicitor for the Prison Officers' Association to settle arrangements for the public hearings and to identify the matters on which oral evidence was required. The Prison Officers' Association provided representation for some of the witnesses. They have been provided with all the evidence except some personal letters from Mr Lodge, which were withheld at the family's request on grounds of privacy, to be shown to witnesses only if the inquiry wished to rely on them.

2.19 In June 2008, I commissioned Dr Nat Wright to conduct a review from a clinical point of view of the care Mr Lodge received in prison. Dr Wright is the clinical director for a cluster of three prisons and a GP adviser to the UK Department of Health Offender Health Unit. He has a special interest in the delivery of primary health care to socially excluded groups and has published extensively in this area. I am grateful to Dr Wright for sharing his expertise. His advice has been invaluable.

The evidence

2.20 The documentary evidence initially consisted of the Prison Service investigation report and supporting evidence, and papers from the inquest that were held by the Prison Service. Mr Lodge's family provided his GP records and some personal letters. The inquiry was able to obtain more Prison Service documents and some police records. In addition, I am grateful to Mr Nigel Meadows, HM Coroner for the Manchester City District, who made available to me all the documentary evidence obtained by his predecessor for the inquest. It included material that the inquiry and the interested parties had not previously seen.

2.21 Before inviting witnesses to give oral evidence, I obtained written statements covering specified questions from 16 people. I wrote to seven individuals to notify them of the inquiry and to invite them to provide relevant information if they could. Five did so. The statements were circulated to the interested parties. Witnesses were provided with copies of relevant documents. Those asked to give oral evidence were told in advance the general areas about which they would be questioned and given notice, in confidence, of possible criticisms so that they had fair opportunity to reply. The inquiry did not want to 'ambush' anyone.

2.22 I am grateful to staff in the Ministry of Justice who helped me contact former members of staff. I was unable to contact Mr Lodge's girlfriend, who was a witness at the inquest and who had a significant involvement in some of the events that the inquiry has examined. Because I have not heard from her I do not know whether she is aware of the inquiry, the subject matter of which may be distressing to her. I have decided not to use her name in the inquiry's report and have called her 'Ms A'. I have also been unable to trace two men who were prisoners at the time of Mr Lodge's death and who gave evidence to the Prison Service investigation and for the inquest.

The hearings

2.23 Public hearings took place at Manchester Civil Justice Centre over five days in September and October 2008, and on a further day in March 2009. One witness was initially unwilling to provide a statement or attend the public hearings. This was a prison officer who is currently taking a career break with an option to return to Prison Service employment. Strenuous efforts were made by the Prison Service to encourage the witness to comply with the inquiry's requests but his view was that if attendance was voluntary he would exercise his choice not to cooperate. This was a witness who was central to the events and who said he had been subjected to harassment when he gave evidence at the inquest.

2.24 After the first five days of hearing evidence, I considered that I could not complete my commission satisfactorily without this officer's evidence. I wrote to the Minister of State, who decided to convert the inquiry into a statutory inquiry under the Inquiries Act 2005. This meant that the inquiry had authority to require witnesses to provide evidence and attend to answer questions. The witness attended on 19 March 2009. .The need for conversion part way through the hearing of oral evidence caused additional delay and expense. This was frustrating for all concerned.

2.25 At the hearings, the solicitor to the inquiry set out the background to the evidence to follow and the issues identified for particular consideration. Counsel for the interested parties made brief opening statements. Ms O'Reilly made a personal statement about her brother, about the experience of his death, about subsequent events and about the family's feelings. Dr Wright answered questions about his clinical review. Eleven other witnesses gave oral evidence. Questions were put to the witnesses only by the solicitor to the inquiry or by me. Before each witness was dismissed I consulted Counsel about whether there were further questions that ought to be explored.

2.26 Counsel for the interested parties made oral closing submissions. They and Counsel for prison officer witnesses gave the inquiry written closing submissions.

2.27 One of the main purposes of the inquiry is to draw lessons that might help prevent similar deaths in future. I invited the Prison Service to examine in detail issues raised by the documentary evidence, to comment, and to tell the investigation the current practice in these matters. The inquiry received substantial written evidence from the Prison Service and heard oral evidence about current Prison Service practice from the present Governor of Manchester, Mr Richard Vince. In particular, the inquiry examined how the care of prisoners at risk of self-harm and suicide has changed since 1998.

2.28 The inquiry issued press releases about the public hearings. These were sent to the Press Association, to three non-governmental organisations and to the national secretariat for the Independent Monitoring Boards. The press releases contained a link to our website which was originally within a section of the website of the Forum for Preventing Deaths in Custody dedicated to Article 2 investigations. The Forum has now been replaced by a Ministerial Council on Deaths in Custody. I am grateful to Lord Toby Harris, Chair of the Independent Advisory Panel to the new Council, for inviting the inquiry to publish its report through the Council's website.

Sonny Lodge's family

2.29 My terms of reference required me to seek to engage Mr Lodge's family members as participants in the inquiry. It is the tenacity of Mr Lodge's family that has led to this inquiry. It was obvious that they should have a central role and I have wanted to conduct a thorough examination of the matters that have caused them suspicion and distress over many years. For the lawyers and for me this was a professional

undertaking. For the family the subject matter was deeply personal. That was bound to set their experience of the inquiry apart from ours.

2.30 There were occasions during the hearings when members of the family intervened, without invitation or notice. Where that was not oppressive to witnesses I accommodated it, recognising the emotive nature of the process for the family. There were times, however, when interventions by members of the family went beyond what was acceptable, levelling accusations at witnesses inside or outside the hearing room. That should not have happened. I repeat the inquiry's regret and apology to the witnesses concerned.

2.31 The family made a request on the final day of hearings to make a further personal statement in addition to their Counsel's closing statement. I felt some sympathy for their request. It was understandable that at the end of this long process the family might feel a pressing need to voice a final word and would leave the hearings frustrated without it. This was particularly so as the need for the inquiry to be put on a statutory basis meant a delay of nearly six months between the initial hearings and the final day. However, the procedures I had adopted in consultation with the interested parties made no provision for the family to speak in person again. Counsel for some of the witnesses argued that a further statement by the family might open a door to fresh allegations that witnesses had no opportunity to answer. Partly for these reasons and, partly, because of unscheduled interruptions earlier that day and previously, I decided that, in the particular circumstances, it would be verging on partiality to permit another statement at that stage.

2.32 Clearly, it would not be appropriate or fair for the family to introduce new evidence or to make new allegations in the closing stages of the inquiry, but I would have preferred to accommodate the family's request to have some personal voice in the closing procedures.

The witnesses

2.33 I am grateful to all the witnesses who gave evidence to the inquiry. Good prison staff are naturally upset by a death in prison and will question for themselves whether they might have prevented it. For some, it was clear that their association with events in the period leading to Sonny Lodge's death affected them deeply and the effects continue today. In most occupations, people are able to make errors or omissions without tragic consequences. Prison staff bear a heavy burden of responsibility, often with little thanks

or recognition. Their actions may be subject to microscopic scrutiny when something goes wrong. Less attention is paid to acts of kindness and it is too little recognised that they save many lives. Prison staff are individuals, with feelings, just as prisoners and their families are.

The report

2.34 This report was sent in draft to the interested parties and to Counsel for the prison officer witnesses. The draft or extracts from it were provided to 31 people identified in the report. In accordance with the Inquiry Rules 2006, I sent 'warning letters' in confidence to people who had not already been made aware that their actions might be criticised. In completing this final report I have taken account of all the replies I received.

The legal advisers

2.35 I am deeply grateful to Mr Chris Topping, the solicitor to the inquiry for his untiring and wise counsel to me throughout the process. I also thank the legal representatives of witnesses and the interested parties who approached the inquiry in a non-adversarial and unfailingly courteous manner and were patient and constructive in their submissions.

Lessons about inquiry procedure

2.36 With the benefit of hindsight, I have considered carefully whether it would have been preferable for the investigation to have been on a statutory footing from the start. *Ad hoc* investigations established on a non-statutory footing have some advantages. They can be set up swiftly. Terms of reference can be easily revised if circumstances require it. Statutory inquiries have the advantage that all those asked to provide evidence know that they are required to do so.

2.37 From my experience in this inquiry, the only disability from the lack of statutory powers was that one reluctant witness could not be compelled to attend. That was remedied when the inquiry was converted. In all other respects I received full cooperation from everyone from whom I sought access to evidence, statements and oral testimony. I consulted the parties throughout the process but, once I had heard the arguments, all the decisions were my own. There has been no constraint on my independence. I have concluded that the reluctance of one witness in the particular circumstances of this case is not good reason to recommend a presumption that Article 2 investigations should generally be statutory inquiries. However, inconvenience, delay

and additional expense might have been avoided if I had asked the Minister to consider converting the inquiry as soon as there were indications that a key witness was reluctant to cooperate.

2.38 The note on investigation procedure that I adopted after consultation with the interested parties is at Annex 2 to the report. In devising procedures that would serve the purposes of the terms of reference and be fair to all concerned, I found that the Inquiries Act 2005 and the Inquiry Rules 2006 provided a helpful guide. However, at that point, I had not contemplated that the investigation might be converted to a statutory inquiry and there were some respects in which the investigation procedure I adopted differed from the statutory rules. For example, the procedure did not specify that witnesses who might be subject to criticism would necessarily be sent confidential warning letters, nor that there was a presumption that documentary evidence would be available to members of the public as well as the interested parties. These inconsistencies caused some complications in the final stages of the inquiry. Those who conduct future *ad hoc* inquiries might find it helpful to have regard to the possibility of conversion to a statutory footing when devising procedures.

2.39 An independent investigator requires discretion to pursue inquiries in the way that he or she finds appropriate to the particular case. I have therefore decided not to make recommendations about procedure but rather certain observations about lessons I learned during the inquiry:

2.40 <u>Observations about inquiry procedure</u>

- The need to compel a key witness to give evidence caused additional delay and expense. Those who conduct similar investigations in future may wish to seek conversion to a statutory inquiry at an early stage if there are indications of a lack of cooperation from witnesses such that compulsive powers may be required.
- The Inquiries Act 2005 and the Inquiry Rules 2006 provide a helpful guide to procedures that are fair to all parties. Those who conduct similar investigations in future may wish to refer to them in devising procedures. Where there is a possibility that an investigation may be converted to a statutory inquiry, it is desirable to avoid disparities between the procedures applying to the non-statutory stage and those that apply in the event of conversion.

- In inquiries of this kind it may be appropriate for the bereaved family to be offered an opportunity to speak briefly in person as part of the closing procedures immediately before the final legal submissions, provided that it is understood that new allegations and evidence cannot be introduced at that stage.

PART TWO

THE EVENTS IN DETAIL

Part Two of the report examines the events in detail and sets out the principal evidence that forms the basis of the inquiry's findings.

Chapter 3:

RISLEY: 15 TO 26 JUNE 1998

Summary

3.1 Sonny Lodge was admitted to Risley prison on 15 June 1998 to begin a sentence of five months. Half the sentence would be spent in prison and half in the community on licence. An F2052SH self harm at risk form was opened. He was placed on medication for withdrawal from drugs. The F2052SH was closed on 25 June. On 26 June Sonny Lodge deliberately injured his arms and was taken to hospital.

Medication for withdrawal from drugs: 16 – 23 June

3.2 When Sonny Lodge was admitted to Risley a reception healthcare officer recorded that he reported a daily heroin habit of 14 years' standing and that he had injected about one gram 72 hours earlier. He also reported smoking about 30 cigarettes a day. On 16 June he was placed on a 'detox' regime comprising dihydrocodeine for seven days and zopiclone for five days.

F2052SH 15 – 25 June

3.3 The healthcare officer in reception opened a Form 2052SH. This was the document in use at the time for recording information about prisoners who were identified as being at risk of suicide or self-harm. (Chapter 14 contains details of the Prison Service's policies and procedures to safeguard prisoners against suicide and self-harm.)

3.4 In the section of the form for the report by the initiating member of staff, the healthcare officer said: he was concerned because Sonny had lacerated his wrists when admitted to Risley the year before and had intimated that he was considering harming himself; and that Sonny said he would be all right if placed in a shared cell. The help the healthcare officer suggested was: (1) close observation/supervision; (2) monitoring by medical staff; (3) support from other relevant professionals/Listeners[1].

3.5 In the section of the form for healthcare assessment, the healthcare officer instructed that Sonny

- should attend for further assessment by the medical officer the next day,

[1] This is a peer support scheme in which selected prisoners are trained and supported by the Samaritans to listen in complete confidence to fellow prisoners who may be experiencing feelings of distress or despair.

- should be located in shared accommodation, and
- should be observed frequently at irregular intervals (the frequency was not specified).

3.6 The continuous medical record shows an entry for the next day but only about Sonny's physical health.

3.7 Sonny was housed in normal location on A wing. The page for initial action by the residential unit manager was not completed.

3.8 A case review was held on 22 June, attended by a senior officer and two officers. Sonny said he had spoken with Probation, who had tried to help him. It was decided that the form should be kept open at least until the next review. The support plan was:

- to remain in shared accommodation
- to contact Probation.
- to attend full-time education classes.

The daily supervision and support record

3.9 During the 11 days that the F2052SH file was open there are 54 entries in the daily supervision and support record as shown in the table below. I have abbreviated or clarified some entries. It is not always possible to tell from the entries whether they were based on passive observation or active interaction. I have highlighted in bold type the seven entries that clearly indicate some conversation. Nowhere on the form is the frequency of required observation specified.

Table 1

16June	0600	Appears to have slept all night. No problems
	0700	Appears asleep at roll check
	1430	**Seen on induction…; states does not feel suicidal but concerned about sentence, warrant and date of release. Advised…Seems cheerful and happy enough**
	1730	Appeared to be OK when unlocked for teatime meal
	1745	Appeared to be OK at tea up
	2100	Seen at start of duty. Seems OK.
17June	0600	Appeared to have slept all night. No problems
	0700	Appears asleep

	0820	Appeared to be OK when unlocked for breakfast
	1215	Lying on bed. Seemed OK
	1120	**Nurse called to a fit. Care given. …Calmed down and an inmate who knows him put in his cell over dinner**
	2100	**Spoke to inmate. Seems to be alright**
	2135	Called by cellmate. Having a fit. Initial care then nurse attended
	2140	**Nurse's entry. Attended to Lodge. Appeared to recover normally from fit. Observations satisfactory. Mattress placed on floor. Windows opened.**
	2205	Got back into bunk by himself
	2300	Sitting on bed eating
18 June	0010	Seems to be asleep
	0530	Appears to have slept alright
	0650	Seems OK at commencement of shift
	1150	**Seen by probation officer, chaplain and PO on a Review Board: [detailed entry about place on education and clarification of release date.]**
	1700	Collected tea. Seems fine.
	1955	In bed at bang-up
	2100	Seen at start of duty. No problems
19 June	0600	Appears asleep. No problems through the night
	0640	Inmate appears asleep. No problems
	1540	Sat on bed. Appears OK.
	2045	Called by cellmate. Having a fit. **Nurse [and senior staff] attended.**
20 June	0600	**Rang bell at 0145 asking for medication. Night Orderly Officer attended. Medication refused as had had all his entitlement. Slept well after this.**
	0700	Asleep at roll check
	1600	**No problems on…[illegible]**
	2100	Seen. OK
21 June	0600	Slept most of the night. No problems.
	0700	Appeared to be asleep.
	2000	Appeared to be OK at lock up.
22 June	0600	Appears to be asleep at roll check
	0645	Appears asleep
	1215	Checked. No problems

	1430	**Review. To be kept on for a few more days**
	1730	Collected tea.
	2100	Appears to be OK
23 June	0600	No problems. Slept all night.
	0700	Appears to be asleep.
	1030	**Spoke to Lodge in his cell and he says he feels much better and is more settled about his problems**
	1830	Seen during …[illegible]…out. Seemed in a good mood.
	1930	Seen during "bang up". Seemed to be in a good mood.
	2100	Appears to be OK.
24 June	0600	Chatting to cell mate till 2300, then slept well rest of the nigh
	0700	Still appears asleep
	1000	To canteen and return
	pm	At work
	1735	Appeared to be OK when unlocked for the evening meal
	2010	Seen at roll check. Seems OK
25 June	0600	Appears to have slept throughout the night
	0700	Seen at morning count. Appeared asleep.

3.10 Most entries are legible. All are signed, mainly with a clear, full signature.

Closure of the F2052SH

3.11 The F2052SH form was closed at a review on 25 June 1998 attended by a senior officer and an officer. They had not attended the previous review. The summary of the review says that Sonny said he had no domestic or prison problems, wanted to have a single cell, was willing to transfer to HMP Kirkham, and knew he could return to F2052SH status at any time just by asking. The section on support plan has been completed, apparently at the review meeting when the form was closed, and says that wing staff were to monitor Sonny's behaviour, especially if he was in a single cell.

Act of self-injury

3.12 At 10.15 pm the next day, Friday 26 June, a nurse was called to Mr Lodge's cell as he had slashed his arms deeply with a razor blade. According to the Inmate Medical Record, he would not let the nurse dress the wound and was verbally abusive. An ambulance was called and he was transferred to Warrington hospital.

Chapter 4:

THE INCIDENT AT WHISTON HOSPITAL: 27 JUNE 1998

Summary

4.1 An incident occurred in a toilet cubicle at Whiston Hospital. Sonny Lodge was alleged to have assaulted a prison officer and was restrained by the escorting officers and an off-duty police officer. One of the officers sustained a dislocated thumb. Sonny Lodge admitted pushing the officer, but claimed this was in response to an assault upon him.

4.2 This chapter sets out the evidence about the incident at Whiston Hospital. It includes the evidence of the two escorting officers and the police officer who assisted and what Sonny Lodge said about the incident in letters and is reported to have said to other people. It includes evidence about the disciplinary history of the officer Sonny Lodge was alleged to have assaulted and about Sonny Lodge's character and credibility.

Uncontested evidence

4.3 Sonny Lodge spent the night of 26 June in Warrington Hospital but was taken to Whiston Hospital for treatment the next day. He was escorted by Officer Clucas and Officer Brownley. The incident occurred at a toilet cubicle off the accident and emergency waiting area. Officer Brownley was outside the cubicle and the door was ajar. Mr Lodge lit a cigarette. Officer Brownley moved forward, pushing the door further open. Mr Lodge pushed Officer Brownley backwards. The officer fell against a trellis screen, knocking it over and falling to the floor. Mr Lodge followed him out of the cubicle. The incident lasted only seconds.

4.4 Officer Clucas ran to assist. He and Officer Brownley took hold of Mr Lodge to restrain him and put him on the floor. Mr Lodge resisted and there was a struggle. Officer Brownley exclaimed that his left thumb was dislocated. An off-duty police officer, Mr Routledge, came to help. Mr Lodge was handcuffed. The police attended. No one except Officer Brownley and Mr Lodge witnessed what happened in the cubicle. Neither Officer Clucas nor Mr Routledge had a direct view of how far Officer Brownley moved towards Mr Lodge. After the incident, Officer Brownley had an operation on his thumb and was medically retired from the Prison Service at the age of 34 on grounds of disablement.

4.5 A governor's adjudication was opened at Garth prison under the Prison Rules but adjourned because the police were investigating. The record indicates that Sonny Lodge pleaded guilty to assaulting Officer Brownley by pushing him backwards.

The contested accounts of what happened: Mr Brownley

4.6 Officer Brownley's evidence is that he opened the door slightly, asked Mr Lodge to put the cigarette out, as it was a no smoking area, and said that if he wanted to smoke they could go outside. He says Mr Lodge swore at him and laughed. Officer Brownley says he then pushed the door open, and ordered Mr Lodge to put the cigarette out, and that Mr Lodge responded by turning round and pushing him forcibly backwards, catching him off balance so that he was thrown into the waiting area and fell against the trellis, which collapsed. Officer Brownley believes that his thumb was dislocated in the struggle that followed, not in the fall, but is not certain when it happened.

4.7 In his statements to the police and to the inquiry, and in oral evidence to the inquest and the inquiry, Officer Brownley firmly denied that he had grabbed, struck, or assaulted Mr Lodge in any other way, before the control and restraint by the approved methods. In oral evidence to the inquiry he said that he pushed open the door and Mr Lodge "*launched himself*" at him.

The contested accounts of what happened: Mr Lodge

4.8 Ms Gregory, a legal clerk, told the inquiry she was present with Sonny Lodge at Huyton police station when he was interviewed and charged. This was on Monday 24 August 1998. The police provided the inquiry with computerised records about the case but no longer had the statements or the tape recording of Sonny Lodge's interview. Ms Gregory's firm no longer had the file. The statements taken by the police from Officer Brownley and Mr Routledge were with the inquest papers but there was no tape or transcript of the interview with Sonny Lodge. Ms Gregory said that she no longer recalled the exact sequence of events but recalled clearly that Mr Lodge adamantly denied assaulting anyone.

4.9 Governor Halliwell at Garth prison spoke to Mr Lodge on 29 June 1998, two days after the incident. He wrote to Governor Williams at Risley that Mr Lodge told him the officer said something to him, he put the cigarette to his mouth, the officer struck him in the face, then held him by the throat, he could not breathe so he pushed the officer. Governor Halliwell said that Mr Lodge pleaded guilty at the adjudication because he

admitted pushing the officer and gave no value to the possibility that, according to his version of events, he might have had cause to defend himself.

4.10 In a personal letter from Garth Hospital, Mr Lodge wrote that he lit a cigarette in the hospital toilet, an officer came up behind him, the officer did not give him a chance to put his hand to his mouth but punched him in the mouth, knocked the cigarette out of his mouth, then rushed forwards and grabbed him by the throat. Mr Lodge said he could not breathe and pushed the officer backwards.

4.11 The Rev Charlotte Lorimer, a chaplain at Manchester prison, gave evidence to the Prison Service investigation and the inquest that Mr Lodge felt a strong sense of injustice about the incident at Whiston. In her statement for the inquest, Ms Lorimer said that Sonny told her that an officer entered the toilet and took hold of him by the throat and he pushed the officer away.

4.12 Father McCann told the Prison Service investigation that Sonny claimed the officer hit him. In evidence to the Prison Service investigation and the inquest, Father McCann said that Sonny denied hitting the officer and that he was not violent and did not commit violent crimes. The coordinating chaplain at Manchester, the Rev Brian Johnson told the inquest Mr Lodge was adamant that he did not assault the officer and was not guilty and that he always pleaded guilty if he had committed a crime.

4.13 Two of Mr Lodge's fellow prisoners at Manchester, Mr Gray and Mr Davies, gave evidence that Sonny had told them about the incident. Mr Gray was Mr Lodge's cellmate on G wing. He told the Prison Service investigation that Sonny claimed to have been *"stitched up"* at Risley but there are no further details in the interview. The Coroner's notes indicate that, in oral evidence to the inquest, Mr Gray said Sonny told him briefly about an incident at hospital and there was a rumour at Manchester. He said Sonny said he tried to strike an officer to escape and two off-duty police intervened. Mr Gray also said that Sonny Lodge said he did not hit an officer but had been *"stitched up by what had happened at the hospital".*

4.14 Mr Davies gave the Prison Service investigators and the Coroner's officer an account of his understanding of an incident in which Sonny said he was having a smoke, the officer told him to put the cigarette out, he went to take another drag, the officer hit him and, in the heat of the moment, he struck the officer back. Mr Davies places the incident in a recess (washroom) area of Risley prison and says that Sonny headed out of

the recess, got about three cells away and was taken back into the recess area and given a beating by officers.

Evidence about the circumstances

4.15 The purpose of the visit to Whiston Hospital was for Mr Lodge to see a surgeon about the injuries to his arms, which were heavily bandaged. The two escorting officers said that Mr Lodge was quiet during the taxi journey. Both said his mood changed at Whiston and that in the waiting area he was agitated and abusive to the officers. Officer Brownley thought this began as soon as they arrived, when Mr Lodge started to make his way into the hospital from the taxi and was told to stay with the officers. Officer Clucas said he became angry when he was admonished for going to the toilet a first time without asking permission. Mr Routledge, the off-duty police officer, said he was aware of Mr Lodge being animated and abusive in the waiting area. He was not certain when that began.

The nature of Mr Lodge's injuries

4.16 The surgeon who saw Mr Lodge at Whiston on Saturday afternoon 27 June, shortly after the incident, gave evidence to the inquest that the lacerations were superficial with no nerve or tendon damage. They were closed with sutures the next day. The surgeon advised that this type of injury would not have significantly reduced his ability to defend himself against another person. He said Mr Lodge was very cooperative.

4.17 After Mr Lodge's death, the forensic pathologist described slash wounds that were healing on his forearms. There were two wounds on the right arm, 17 and 10 centimetres long, and three on the left arm measuring 11.14 and 4.5 centimetres.

4.18 As part of his clinical review for the inquiry, Dr Wright was asked to advise whether the nature of Mr Lodge's self-inflicted injuries could have precluded him from physically pushing Officer Brownley backwards.

4.19 Dr Wright advised that in his experience, self-inflicted injuries do not preclude an individual from the potential for physical violence towards professionals. Mr Lodge's self-inflicted wounds, whilst extensive, were to skin and superficial soft tissue. Serious or permanent injury to nerve or muscle tissue could have the potential to limit an individual's power to exert force but there was no indication in the records of any seriously or permanently injured nerve or muscle tissue. This was confirmed by the surgeon's report.

Officer Brownley's injury

4.20 Dr Wright also commented that thumb dislocations were generally caused by a moving object (such as a cricket ball), by falling on to the thumb or by entrapment. He said he could understand how Officer Brownley's injury might have been sustained in his fall but otherwise he asked whether it was an aggravation of a previous injury. Officer Brownley told the inquiry he had experienced no such injury to either hand before the incident at Whiston.

4.21 An accident report dated 27 June stated, *"Duty doctor reported extensive damage to ligaments and surrounding tissue on left thumb, including*... [illegible in copy] ...*and listed for invasive surgery."*

4.22 In his statement to the police on 14 August 1998, Mr Brownley said that his thumb snapped back into place but he was unable to use his hand owing to ligament damage and pain. He said he been in hospital for an operation where his thumb was pinned, ligaments were repaired and his thumb was placed in a splint. Since the incident he had been unable to work. In his statement to the inquiry, Officer Brownley said he had physiotherapy for 12 months after the incident and was eventually informed that he was 20% medically disabled.

Contemporary records about the incident

Accident report

4.23 Officer Brownley signed a Prison Service accident report on 27 June. This records details of the injury to his thumb (quoted in paragraph 4.21 above), says that the injury occurred during necessary restraint and that the officer was assaulted.

Adjudication under the Prison Rules

4.24 A memorandum to a governor at Garth on 28 June from a governor at Risley identified only by initials, asked for an adjudication to be opened and adjourned because the incident had been referred to the police *"who will formulate charges"*. A governor's adjudication was opened at Garth on 29 June. Sonny Lodge was charged with assaulting Officer Brownley. The Notice of Report (Form F1127) said: "*You assaulted Officer Brownley by pushing him backwards."* According to the record of the adjudication Mr Lodge pleaded guilty.

4.25 The report to the Governor (Form F254) reads:

"At 1320 on 27.6.98…I told... [Prison No.].. .to extinguish a cigarette …he had lit in the toilet. He ignored me. I then told him to put his cigarette out, due to it being a non smoking zone. He turned towards me and pushed me causing me to lose my balance…"

4.26 The notice appears to have been completed by Officer Brownley and is signed in his name with a signature which appears similar to his. However, Mr Brownley told the inquiry that he did not complete the notice and that the signature is not his.

The Inmate Medical Record

4.27 The medical officer at Garth examined Mr Lodge on 29 June. He drew a diagram in the continuous medical record indicating a linear bruise at the side of his neck. There is no comment on the diagram.

4.28 Officer Brownley, Officer Clucas and Mr Routledge said they were not aware of the bruise to Mr Lodge's neck and could not say whether it occurred during the restraint.

Records that were not completed

4.29 Prison Service policy at the time required certain other records to be completed about an incident of this kind. The inquiry could not locate any evidence that they were completed at the time and none of the witnesses suggested that they had been. The records in question were:

- Prison Service form F213 Injury to Inmate

  This form is used to report injury to prisoners and can be completed by any member of staff. There was no F113 Injury to Inmate form in Mr Lodge's medical record or any other file seen by the inquiry and it has not been suggested that one was completed.

  The Prison Service says that if there was a mark on Mr Lodge an enquiry should have been made by staff into the nature and circumstances of how it was caused and appropriate paperwork raised if it was deemed an injury.

- Use of Force records

  There were no records about the use of control and restraint on Mr Lodge at the hospital. Officer Clucas told the inquiry that when he returned to the prison he

was required to resume wing duties and could not recall that anyone spoke to him about the incident at the hospital or about paperwork.

The Prison Service says that Prison Service Standing Order E, in force at the time, required a report to be completed only when mechanical restraints, special accommodation or staves were used in the course of restraining a prisoner. However, use of force statements were a requirement and officers were taught to complete them during their training. The statements were often in the form of a memorandum stating only the fact of a restraint according to authorised techniques and not the circumstances.

Other relevant circumstances

4.30 The inquiry has learned that prison managers at Risley had some cause for concern about the incident.

Governor Williams' evidence

4.31 In a memo to the then Governor in Charge at Risley on 30 June 1998, the then Head of Residence at Risley, Governor Williams, said that on Tuesday 23 June she had spoken to Officer Brownley about timekeeping when he been late for work on the first day of an 18 month driving ban. In the memo she also referred to rumours, which she said were also known to certain senior uniformed staff, that Officer Brownley intended to engineer an assault by a prisoner in order to go on sick leave if he was banned from driving. She said she had discussed Mr Brownley's disciplinary record with him, made it clear she had not been impressed with what she had seen of the performance of his duties, and advised him against going sick.

4.32 In oral evidence to the inquiry, Governor Williams stated that she was quite clear that she had spoken to Mr Brownley specifically about the rumour that he intended to engineer an assault and she had subsequently spoken to his line managers about the conversation.

4.33 In a statement to the Coroner's officer, Governor Williams said Officer Brownley was aggrieved that he had applied to transfer to Manchester prison but been turned down. She also said that the Governor in Charge had said that the prison could not investigate Mr Lodge's allegation against the officer as the incident had been referred to the police.

4.34 In oral evidence to the inquiry, Mrs Williams said that she had assumed that the whole matter would be investigated by the police, including Mr Lodge's allegations against Mr Brownley:

"My view now is that when I went to see Governor Harrison and he told me the matter was being dealt with and would be investigated, that I understood that meant all of the matters would be investigated. He had copies of all of the letters and it would all be investigated."

Governor Halliwell's evidence

4.35 Governor Halliwell, who spoke to Mr Lodge at Garth prison, wrote to Governor Williams on 2 July to inform her of Mr Lodge's account of the incident. In his memo he said that, although there was no support for what Mr Lodge said, he believed there was substance to his version of events. Governor Halliwell said he *"had advised [Mr Lodge] to tell the truth to the interviewing police as I believe he has told me".*

4.36 When questioned by the inquiry about why he believed Mr Lodge was telling the truth, Governor Halliwell said it was *"Basically because he wasn't wanting to shift the blame. The way that he represented himself, he wasn't looking for anything, he wasn't seeking any favours. And he was also quite apologetic in as much as he was saying, 'I shouldn't be telling you this'. And he was also concerned, at one stage, about getting the officer into trouble. And he was reluctant to … explain to me fully about what had happened."*

Mr Halliwell told the inquiry that he formed his opinion and wrote the memo without any knowledge of the officer involved. He commented that it was common, in prisons, to submit pieces of information *"even though you haven't got a full picture yourself. It may actually form part of a bigger picture. It could be part of a jigsaw…. if Bernard's [Sonny Lodge's] description of the events was also supported by the officer's past behaviour it might be useful for the Governor of Risley to have in his possession, if considering any further action at any time."*

Mr Brownley's evidence

4.37 Mr Brownley told the inquiry he was not aware of a rumour that he intended to contrive an assault. He did not recall any conversation with Governor Williams about it, though he recalled a meeting about timekeeping. He agreed that he had been banned from driving but said he was reorganising his domestic arrangements so that travelling

would not be a problem. He said he did not recall applying for a transfer to Manchester but when shown documents about this he agreed that it appeared that he had applied before 4 June 1998, appealed against a refusal, attended an interview at Manchester on 22 July but was again refused. Officer Brownley pointed out that he was being asked to recall events from over ten years ago.

Officer Brownley's disciplinary record

4.38 The inquiry has received evidence about Officer Brownley's disciplinary record. In 1995 he was disciplined for assaulting a prisoner. The circumstances of the assault were that during a night shift a prisoner was playing a radio loudly. Officer Brownley opened the cell intending to seize the radio. Officer Brownley admitted misconduct but said, in mitigation, that the prisoner had provoked him. To the inquiry, Officer Brownley said that the prisoner had come at him and he had responded first in self-defence then swung at him again.

4.39 The matter was not referred to the police. Officer Brownley received a loss of increment for 12 months from October 1995 and a final written warning to expire in five years, on 1 July 2000, instead of the usual period of three years. He was also placed on a 12 month period of special supervision and required to attend courses in personal development and anger management. There were two reports of Officer Brownley resorting to verbal anger during the period of supervision. At the end of the 12 month period his performance was deemed to be satisfactory.

The character and credibility of Sonny Lodge

4.40 In evaluating the evidence about several issues in this inquiry, I have to consider the character, conduct and credibility of Sonny Lodge. I have set out my consideration of this in full in Chapter 18 in relation to Sonny Lodge's claims that he was victimised by prison officers.

4.41 Most pertinent to the incident at Whiston is whether Sonny Lodge had a propensity for violence. The relevant evidence known to the inquiry is that:

- He had one conviction for causing actual bodily harm in 1987, at the age of 17, incurring a fine of £100.
- His sister said he was not aggressive and she had never known him to pick a fight.

- The day centre manager said Sonny Lodge thought he was one of the big boys but he never was.
- In evidence to the Prison Service Investigation and the inquest Father McCann said that Sonny Lodge told him he was not violent and did not commit violent crimes.
- In May 1998 Sonny Lodge was banned from Manchester Drug Service for six months for threatening behaviour towards one of the doctors.
- The diagnosis of dissocial personality disorder by the psychiatrist at Warrington Hospital was only tentative but, from the records, Dr Wright found it appropriate and said that risk of violence and threatening and abusive behaviour could be characteristic of the disorder.

Chapter 5:

27 JUNE TO 9 JULY 1998: ASSESSMENT AT WARRINGTON HOSPITAL; GARTH PRISON

Summary

5.1 Sonny Lodge was assessed by a psychiatrist at Warrington hospital who recommended psychiatric follow-up and medication and found little evidence of any risk of suicide. From hospital, Sonny Lodge went to the healthcare centre at Garth prison where he remained until 9 July. A nursing care plan was devised aiming to relieve depression and risk of self harm. The prison medical officer made a detailed record of a lengthy interview. He recommended that Sonny needed counselling but not medication. An F2052SH suicide and self-harm prevention plan was open throughout the period.

Assessment at Warrington Hospital - 27 June 1998

5.2 At Warrington Hospital on 27 June, Mr Lodge was seen by a staff grade psychiatrist, whose report formed part of the discharge information that accompanied Mr Lodge to Garth.

5.3 The psychiatrist's report says Sonny Lodge asked if he could help him to get out of prison. Mr Lodge said his main problem was mood swings that he had experienced since childhood. He said he had been hearing music and voices from inside his head since he was a child and the voices had been shouting at him but not anything else. His mood varied with his circumstances and he felt good when out of prison but inside got low. He did not report delusions, lethargy, feelings of worthlessness or any suicidal plans. He said that he had taken overdoses and cut his arms in the past, and that these were an impulsive response to stress and not premeditated. The psychiatrist recorded his impression as dissocial personality disorder, adjustment disorder (possibly mild depression), no suicidal plans. He proposed that Mr Lodge needed further psychiatric follow-up in the future *("ie re-assessment")* and recommended medication, Cipramol (an antidepressant) and Tegretol (an anticonvulsant), but did not prescribe it as Mr Lodge was returning to prison healthcare.

5.4 The psychiatrist's witness statement to the inquest said that he found little evidence of any significant suicide risk and, on applying the suicide indicator form used by the Warrington Community Trust, Sonny Lodge scored 15 which was low risk.

F2052SH: Garth 29 June to 9 July

5.5 Garth prison provided inpatient healthcare for Risley. On arrival at Garth on 29 June, Sonny was admitted to the hospital wing and a healthcare officer opened a fresh F2052SH. The reason he gave was that Sonny had been admitted from hospital following repair of self-inflicted injuries. The healthcare officer completed the nursing assessment on the form. He said that Sonny's mood on arrival was pleasant and cooperative. He was placed in a gated cell in the prison hospital with maximum supervision and staff were to observe his physical condition in case of any complications after the surgery to his arms.

5.6 Next morning, the medical officer conducted a lengthy examination recorded in the Inmate Medical Record (IMR) and summarised in the Health Care Assessment in the F2052SH. He found Sonny emotional at present, with no evidence of mental illness and no intention of self harm on arrival at Garth. He described him as seeming a quiet, pleasant individual. He concluded that he needed counselling.

5.7 The medical officer prepared a healthcare discharge report for the F2052SH on 1 July in anticipation that Sonny would be transferred from the healthcare centre to a residential unit. He noted that he had been very settled since admission and no concerns were raised. He had long standing drug abuse problems and *"recent bereavements".* The recommendation on management within the residential unit was that Sonny *"needs ongoing support"* and his "*long-term drug abuse issues needed addressing."* In fact, Sonny Lodge was not discharged but remained in the healthcare centre throughout his time at Garth. The IMR says he was being kept at Garth because an investigation was pending at Risley.

5.8 No support plan or case reviews are recorded in the F2052SH but the Inmate Medical Record contains a nursing care plan which recorded the patient's problems/needs, the aim of care/goal, nursing action and provision for review dates and a daily record of nursing care.

Nursing care plan

5.9 The goal indicated in the plan was to relieve depression and thus possible risk of self-harm. The planned actions were:

- to give medication and monitor the results;

- continued assessment and recording of speech and thought content, affect, appetite, sleep problems, objective and subjective behaviour
- encourage the inmate to ventilate his anxieties and concerns
- build a therapeutic relationship based on trust
- where available to participate in ward activities.

5.10 The nursing record for 29 June says that Mr Lodge's sister was contacted and told she could visit him next day. In her statement for the inquest, Sonny's girlfriend, Ms A, said that a nurse at Garth telephoned to ask if she could visit. The nurse arranged for Ms A to visit Sonny and one of her brothers on the same day but when she arrived she was not able to see Sonny. She did not know why but arranged another visit for 8 July.

5.11 From 1 July, Sonny Lodge was considered fit for normal location and remained in Garth hospital as a *"lodger"*. He was no longer considered to need nursing care and the nursing record was not maintained after that date. On 9 July, he attended an outpatient appointment at Whiston hospital and from there was transferred to HMP Manchester where the F2052SH remained open.

Daily supervision and support record

5.12 During the 11 days that the F2052SH file was open at Garth there are 27 entries as follows in the daily supervision and support record. The initial observations were entered in both the nursing record and the F2052SH. I have abbreviated or clarified some entries and highlighted in bold type the 13 entries that imply conversation rather than just observation – though it is not always possible to be clear about this.

Table 2

		F2052SH	Nursing record
29 June	1930 1630	**Appeared pleasant in mood on arrival, cooperative in manner. No immediate threats of self-harm expressed. Will observe through the night** **Slept from 11 pm. Talked about reason for self-harm being deaths of children and niece. Talked of hearing voices telling him to self harm and said he self harmed as a way to relieve stress. Slept well through the night.** **Seen and checked by Dr today. No suicidal intent voiced. Moved from gated cell to ward**	**Inmate discussed acts of self-harm saying he was down because of the deaths of children and niece which brought memories back. Talking about hearing voices telling him to self-harm saying they were down to his drug history. Said self-harming relieved stress.** **…Settled day. No other problems presented. Sister contacted and informed she can visit him tomorrow.**
30 June	0630 1915	Appears to have slept well Taking prescribed medication and on 12 x hourly observation, appears to be settled. No expressions of suicide	
1 July	0630 1030 1130 1945	Appeared to have slept **Doctor's entry. Spoken at length – still unsure whether he should stick with his girlfriend or move to Ireland to be with his sister. Worried he will not get the help he needs at Risley. No sign of agitation/distress. Fit for transfer** Being kept at Garth for time being **No thoughts of self-harm noted nor expressed**	
2 July	0630 1050	Appears to have slept **Seen by doctor – to be kept at Garth pro tem**	
3 July	0630 0930 1830	Appears to have slept **Doctor's entry. Awaiting enquiry at Risley – no sign of any distress** **No thought of self-harm expressed throughout the day**	

4 July	0630 1650 1930	Appears to have slept **No signs of self-harm expressed** No apparent problems noted	
5 July	0630 1545	Appears to have slept **No thoughts of self-harm expressed today**	
6 July	0630 1540	Appears to have slept **No thoughts of self-harm expressed throughout the day. Settled at time of report**	
7 July	0630 1850	Observed regularly throughout the night. Appears to have slept well. **No ideas of self-harm expressed. Mood appears stable**	
8 July	0630 1430	Observed regularly throughout the night. Appears to have slept well. **Doctor's entry. Notified that being transferred to Manchester tomorrow after out-patient department at Whiston. Bernard happy at move back to Manchester. Will be fit for ordinary location at Manchester**	
9 July	0630 0800	Observed regularly throughout the night. Slept for varying periods. Doctor's entry: fit for discharge	

5.13 A time is entered for each entry. Most entries are legible. Most are signed, mainly with a clear full signature or a signature and printed name.

Chapter 6: F2052SH AT MANCHESTER PRISON

Summary

6.1 Sonny Lodge was transferred to Manchester prison on 9 July. He was assessed by a nurse and the medical officer. The F2052SH form was kept open until 20 July. After induction in K wing, Mr Lodge moved to E wing. He started work in the upholstery workshop but on 24 July he was sacked and charged with endangering health and safety with a staple gun.

Healthcare assessment

6.2 On admission to Manchester Sonny Lodge was interviewed by a healthcare officer who made a detailed note in the Continuous Medical Record about their conversation, in which Sonny talked about the reasons for his self-harm and his present feelings and the healthcare officer assured him that he could talk to any member of the health care team at any time.

6.3 The next day Sonny saw the medical officer. The entry in the medical record is not easy to read but it appears Sonny said that he had been depressed and upset when he slashed his arms but now felt better and not suicidal at all. He seemed calm and had no suicidal ideation or intention. The medical officer recorded a plan in the medical record: shared cell for two weeks and review; no medication for the time being; on F2052SH and review.

6.4 No support plan was recorded on the F2052SH form which was opened at Garth and accompanied Sonny to Manchester.

Daily supervision and support record

6.5 For the 12 days the form was open at Manchester, the 54 entries in the daily supervision and support record were as follows. I have abbreviated or clarified some entries and highlighted in bold type the 10 entries which appear to draw on conversation rather than just observation.

Table 3

9 July	1335	Received from Garth. Seems fine.
	1400	**Entry by health care officer. Reception interview. OK. Not overly depressed and not expressing signs of self-harm. States he has a lot to live for now.**
	1609	**Entry by Senior Officer on K wing. Spoke to this man shortly after he arrived on K wing. He states that he has problems but is coping well and the quicker he is off this form the better. I told him I would speak to him again in a few days.**
	1700	Appears Ok
	2030	Appears OK
10 July	0015	Appears asleep
	0320	Appears asleep
	0630	Appears asleep
	1650	**Stated he was OK**
11 July	0030	Appears asleep
	0330	Appears asleep
	0630	Asleep
	0830	Seen at breakfast. Appears OK
	1425	**Spoken to after arriving on E wing. Seems OK**
	1900	**Spoken to and stated he would like to come off. Told him with being new on the wing we will review in 2 weeks time.**
	2050	Appears OK. Talking to padmate
12 July	0030	Appears to be asleep
	0600	Appears to be asleep
	0645	In bed asleep
	1700	No problems
	2010	Talking to padmate. OK
13 July	0150	Appears asleep.
	0525	Appears asleep.
	0630	In bed asleep.
	1915	**States he's "sweet" and would like to come off this asap**
	2400	Appears asleep.
14 July	0130	Appears asleep.
	0330	Appears asleep.
	2400	Appears asleep.
15 July	0145	Appears asleep.
	0330	Appears asleep.
	1310	In his cell watching tv

16 July	0100 0355 0630 0630 1300	Appears asleep Appears asleep. Appears asleep. No problems **Spoke to him at dinner. Appears to be OK.**
17 July	0130 0415 0630 1145	Appears asleep. Appears asleep. On bed. Asleep Appears asleep.
18 July	12.00 unclear 0900 11.55	Appears asleep Appears asleep OK. Awake OK. Talking to cell mate
19 July	2.30 4.30 0845 1200 10.05	Appears asleep Appears asleep. **Seen at breakfast. States OK** **Spoke to, quite cheerful and stated no problems.** **Awake. Said OK**
20 July	12.30 2.30 0600 1120	Appears asleep Appears asleep Appears asleep. Case review

Most entries had a legible signature.

Closure of the F2052SH

6.6 Sonny Lodge was on K wing, for induction from 9 July then moved to E wing on 11 July. The only recorded case review at Manchester was on 20 July and attended by SO Dodds and Officers Buckley and Thompson. The review summary was *"Lodge has no feelings of self harm and is coping quite well. Was speaking quite openly about why he cut up and the review team feel satisfied."*

6.7 An entry under support plan says *"maintain CC review 14 days"*. I understand this to mean that Sonny was to remain in a shared (communal) cell with a further review to follow in 14 days. It is not clear whether this entry was made at the closing review or some earlier date.

6.8 When the F2052SH was closed, the distinctive orange folder was returned to Sonny Lodge's core record in the prison's central filing system. There was no note at this

point on the history sheets kept on the wing that an F2052SH had been open and closed, though there is a later reference to it on 25 July in an entry by Officer Smyth (see below paragraph 7.34). For the remainder of his life, staff at Manchester did not consider Sonny Lodge to be at risk of suicide or self-harm.

Disciplinary charge

6.9 Four days after the closure of the F2052SH Sonny Lodge was sacked from the workshop and charged with endangering health and safety by firing staples from a compressed air gun. At the adjudication, a governor imposed seven added days suspended for one month, seven days stoppage of 100% of earnings and seven days stoppage of all privileges. Losing his job and the temporary loss of privileges significantly altered Sonny's access to occupation and resources for the remainder of his sentence and prompted the first of several wing moves.

Chapter 7:

LIFE AT MANCHESTER PRISON: TRANSFERS BETWEEN WINGS AND SONNY LODGE'S CLAIMS OF VICTIMISATION

Summary

7.1 Sonny Lodge moved wings several times at Manchester. This chapter:

- contains information about the environment and daily life at Manchester at the time, drawing on evidence given directly to the inquiry, criticisms by the prisons inspectorate of the regime on K wing and a disciplinary system which permitted officers to punish prisoners without due process or proper supervision
- describes the facilities available to prisoners under the Prison Rules and the circumstances in which they can be removed as a punishment
- draws on prison records and evidence to the inquiry about Sonny Lodge's various moves between wings, and punishments he received as a result of adjudication and through the wing-based disciplinary system
- draws on Sonny Lodge's personal letters in which he complained of bullying by staff and expressed his feelings about day-to-day events. Although outgoing letters had to be left unsealed for random inspection, there is no evidence that the content of these letters was known to prison staff at the time.

(There is a list of acronyms and references at Annex 4.)

Manchester Prison

7.2 Manchester prison is a Victorian prison of traditional design which was temporarily closed after serious disturbances in 1990. The prison reopened in 1994. In 2003 it became part of the high security estate. It acts as a local prison serving the courts in the north-west of England and also holds Category A prisoners (those for whom the highest level of security is required).

7.3 Wings A to E of Manchester prison form the *"Bottom Prison"* which was fully refurbished after the disturbances. The cells there were mainly designed for two prisoners and had *"full integral sanitation"* (a toilet in a cubicle). The Bottom Prison was a

working prison occupied mainly by convicted prisoners. Prisoners on E wing were on the enhanced regime and had in-cell television.

7.4 Wings G, H, K and I formed the *"Top Prison".* They contained cells designed for one prisoner but which were regularly occupied by two. The cells had *"simple sanitation"* (an unscreened toilet in the cell). The Top Prison held mostly remand prisoners. In 1998, there was no provision to offer prisoners in the Top Prison work or education.

7.5 After an offence against Prison Rules on 24 July Sonny Lodge was based in the Top Prison until he was moved to the segregation unit on 27 August.

Prisoners' Facilities

7.6 In 1998 Prison Service Standing Order 4 on Facilities (Standing Order 4, paragraph 4.23) described the facilities permitted to prisoners and the circumstances in which they might be withheld. Prisons were required to allow certain facilities to all prisoners. Other facilities were discretionary. The list of items that prisoners had to be allowed included, among other things:

- at least six newspapers
- at least three books
- games
- hobbies and writing and drawing materials
- a radio and another audio player with records, tapes or discs
- smoking requisites except where smoking was prohibited.

7.7 Sentenced prisoners were permitted to spend cash, up to a weekly limit specified by the Governor, through a prison shop (called canteen) and certain mail order arrangements.

Association

7.8 Whenever practicable, prisoners were to be given the opportunity to take part in association with other prisoners. Standing Order 4, based on the statutory Prison Rule 45, instructed that a prisoner might be excluded from association only in specified circumstances. These were:

- in his own interest or for good order and discipline;

- if refractory or violent;
- for restraint;
- pending the hearing of a disciplinary charge; or
- as a result of a punishment awarded at an adjudication.

Punishments under the Prison Rules

7.9 The Prison Discipline Manual dating from 1995 (PDM 1995) provides that the facilities listed in Standing Order 4 may be withdrawn from adult offenders for up to 42 days as a punishment, but specified that certain facilities should not normally be withdrawn. These were:

- general and educational notebooks
- drawing books
- radios
- attendance at educational classes
- correspondence courses
- purchase of stamps and phone cards.

In addition, adjudicators were authorised to stop all or part of an adult prisoner's daily pay, up to an amount equivalent to 42 days full pay.

7.10 The current advice on Adjudications is set out in Prison Service Order (PSO) 2000 which came into force in January 2006. The provisions on punishments are not markedly different from the earlier guidance but state that the purchase of stamps and phone credits and the use of the telephone should not normally be forfeited unless the circumstances of the offence are directly related to their abuse. The maximum amount for stoppage of earnings is raised to 84 days full pay but the provision repeats that prisoners should normally be able to buy phone credits and stamps.

The Incentives and Earned Privileges Scheme

7.11 The Incentives and Earned Privileges Scheme (commonly known as IEP or IEPS) is a system for linking the facilities that each prisoner is permitted to assessments of his/her individual behaviour and performance. Every prison is required to allocate prisoners to basic, standard or enhanced regime levels, which attract different levels of

privileges over and above the facilities that prisons were required to permit under Standing Order 4. They include, for example, extra visits, extra time out of cell and permission to spend extra private cash. In some prisons, particular wings were allocated to the different levels of regime; in others, prisoners from all levels occupy mixed wings. Governors were required to draw up local schemes within the national framework. The IEP scheme was introduced in July 1995 in Instruction to Governors (IG) 74/1995.

7.12 The current guidance on the IEP Scheme is Prison Service Order (PSO) 4000 *Incentives and Earned Privileges, Earned Community Visits and Compacts.* Prisoners on standard and enhanced, but not basic, levels are eligible for access to in-cell television where it is available. However, all prisoners considered to be at risk from self-harm/suicide (or disadvantaged by disability or in other ways) can be considered for in-cell television irrespective of privilege level on a case by case basis.

H wing

7.13 Governor McColm told the inquiry that regime levels at Manchester in 1998 were based on location. There were separate wings for prisoners on the enhanced, standard and basic regimes. A report of an inspection at Manchester prison in 1995, published by Her Majesty's Chief Inspector of Prisons (HMCIP) in 1996, expressed concerns that the basic unit (then on I wing) was seen by prisoners as overbearing and inflexible (HMCIP 1996, paragraphs 5.22-5.31, especially 5.27). Governor McColm was appointed to change this. He told the inquiry there were concerns about prisoners being locked up, of having little access to any regime or any association or exercise and, for example, the way they were inducted onto the unit was *"virtually having the rules shouted at them".*

7.14 Governor McColm said that he felt the wing had been set up on the wrong basis and without proper management. It was verging on being a segregation unit but without the safeguards that applied there. He said it was not difficult to turn the wing around. It was not typical of the prevailing culture at Manchester where he found that the vast majority of officers were decent and caring.

7.15 The location for basic regime prisoners was moved from I wing to H wing. In a report published in January 1998, of an unannounced inspection in October 1997, HMCIP says their concerns had been addressed and managers and staff were found to be taking a more sensitive and helpful approach. HMCIP found that prisoners knew why they had been placed on the basic level and were encouraged to progress. Most had a

history of persistent infringement of minor rules. Prisoners on H wing told the inspectors they had been properly treated by staff. One or two prisoners said they were happy to remain on H wing because of the regular and satisfactory provision of the routines (HMCIP 1998, paragraphs 3.18-3.24).

K wing

7.16 The report of the full inspection conducted in October 1995 explained that K wing was primarily an induction unit but also operated a more restricted regime as a 'half way' stage between I wing and the regime on other wings (HMCIP 1996, paragraph 6.08).

7.17 According to the report of the October 1997 inspection, K wing held up to 228 prisoners who were new or had undergone a change of circumstances (HMCIP 1998, paragraphs 3.25-3.37). There was a constantly changing population. Standard regime applied. Although there was electricity for in-cell television, only the Listeners[1] (who were on the enhanced level of the incentives and earned privileges scheme) were allowed televisions. HMCIP found the regime extremely restricted. A small workshop occupied some prisoners but for most there was a daily period of only two to three hours out of their cell. Association times were reduced at weekends.

7.18 HMCIP found limited interaction between staff and prisoners, relationships were formal with little of the usual banter. Rigid reliance was placed on prisoners making written applications when they wanted anything. Staff were clearly in control and a tightly ordered environment had been created but at the cost of human relationships. During association there was little evidence of officers talking to prisoners. They spent most of their time simply observing and supervising prisoners. There was no functioning personal officer scheme. Relationships between staff and prisoners needed to be improved. Introducing an effective personal officer scheme was seen as the next major step by the Governor and management.

7.19 In November 2001 HMCIP conducted another full inspection. Further concerns were expressed about K wing, which was said to be *"the most volatile wing"*:

"We found too many bored and poorly motivated prisoners. Moreover, staff on duty were reluctant to engage with prisoners, tending to stay at one end of the long landings, where they would have been unable to identify or intervene in bullying within cells. The 1990 disturbances were still an important part of the prison's folk memory (and indeed

[1] Prisoners trained by the Samaritans to offer confidential peer support.

the actual memory of many of its staff and prisoners); and this added to the perception of vulnerability on both sides." (HMCIP 2002, page 4)

The wing-based disciplinary system

7.20 In 1996, the inspection report noted that prison officers could deprive prisoners of association periods for a variety of reasons and about 10 per cent of the prisoners on K wing were so deprived. Loss of association meant, for example, no access to showers or telephones, and the inspectorate was dismayed to find little written evidence of why prisoners were being dealt with in this way (HMCIP 1996, paragraphs 7.23-7.24).

7.21 The Director of Regimes at Manchester issued amended guidelines on restricting facilities on 1 October 1996. They stated that the restriction of access to facilities should be recorded on the wing record maintained for the purpose and on the prisoner's history sheets so that any pattern of misbehaviour could be identified. All privilege restrictions were to be approved by the wing Senior Officer (SO), usually following a recommendation from wing officers, and with the prisoner's personal officer involved if possible. For prisoners on standard or basic level the possible sanctions were loss of association to be imposed for one day only per infraction or withdrawal of one electrical item for one week.

7.22 In 1998 HMCIP expressed concern again that staff still had delegated authority to deny association to prisoners who, in their opinion, infringed minor rules and regulations, but that no warnings were given and there was no proper managerial oversight of the process.

7.23 From paragraph 3.34 of the report:

"All the officer had to do was to record in a book the prisoner's name and state why association had been stopped. Although this also required the counter signature of a SO, it was not done in some cases." (HMCIP 1998, paragraph 3.34)

The report called the scheme:

"an arbitrary system with no right of appeal. Each day some prisoners were not being unlocked for association for minor infringements that would not have been considered sufficiently serious as to warrant being placed on governor's report. There was no form of investigation into the alleged offence or the circumstance relating to it and no warnings appeared to be given." (HMCIP 1998, paragraph 3.34)

HMCIP recommended that an effective system of managerial supervision over staff decisions should be implemented.

7.24 A memorandum dated 1 October 1999 instructed that the authority to award loss of association was withdrawn and drew wing managers' attention to the incentives and earned privileges system, through which unacceptable behaviour should be addressed.

E wing: 11 July to 25 July

7.25 As a sentenced prisoner, Mr Lodge was on E wing in the Bottom Prison from Saturday 11 July to Saturday 25 July. The F2052SH was reviewed and closed on 20 July. By Thursday 23 July he had started work in the upholstery workshop.

7.26 On 17 July, Officer Thompson recorded in Mr Lodge's history sheets[1] that, at his request, he made enquiries about whether the police would pursue the alleged assault on Officer Brownley at Risley and told Mr Lodge that it was not yet known whether the charge would be pursued.

7.27 In a letter the same day, Mr Lodge asked his girlfriend to arrange for his solicitor to visit *"as I have just been informed the police will take action for what happened at Risley"*. He claims to be confident there is nothing to worry about. In the same letter he says that officers are *"still trying to get me to kick off…now they know the score".*

7.28 Mr Lodge's letters from E wing relate several adverse encounters with prison staff. In an undated letter, Mr Lodge says he has just done five weeks (which would be Saturday 18 July) and has to go in front of the governor tomorrow for *"that little incident the other morning at breakfast"*. He also writes disparagingly about prison officers. He says they are trying to provoke him.

7.29 In another undated letter from the period before Mr Lodge started work, he refers to a reprimand from a governor and more problems with prison officers on the way back. On Sunday 19 July, Mr Lodge writes that he has *"just been nicked again, right in the middle of church".* He seems to interrupt the letter, saying he has just been shouted at on the landing and *"here we go again…for another nicking".* Resuming the letter, he says he has just been banned from church and had *"another bollocking".* In another undated letter from E wing, Mr Lodge tells his girlfriend he has just had another problem

[1] Form F2052A Record of Events is commonly known as the 'history sheets'. It forms part of a prisoner's individual record and contains a record of significant events. It is held on the residential unit where the prisoner is based.

with officers in the kitchen for going down for seconds but it ended *"in a joke, so no charge sheet for that"*. There are no records in the history sheets correlating with any of these incidents. During this period Sonny was still considered to be at risk of suicide or self-harm. The F2052SH form was closed on 20 July.

7.30 An entry by SO Lowe in the history sheets on 22 July says that he warned Mr Lodge at 6 pm for being incorrectly dressed. When he was still improperly dressed at 7.20 pm he was locked up for the rest of the evening. Mr Lodge's account, in his letter of the same day, is that he had just got on the pool table when he was *"nicked … for not having his shirt tucked in at the back".* According to his girlfriend, he saw this as playing games with him.

7.31 In a letter dated Thursday 23 July, Mr Lodge says he was in work all morning: *"What a laugh. I had about 90 staples stuck in my head.*" He claims the officers are *"still"* trying to provoke him but he is not rising to the bait. In an undated letter that seems to be from the same day Mr Lodge says he is doing fine except for the officers who *"seem to be trying to get me on one*". He says he knows he has only four weeks to go and is trying to *"get on with it"* but "*if this carries on, someone is going to fall and I know it won't be me*." He expects to be *"in front of the governor again*" and wonders what the officers will come up with next: maybe *"nicking me for snoring."* Mr Lodge says he still has no phonecard to make telephone calls but hopes to get one on Sunday or Monday.

Disciplinary offence

7.32 On Friday 24 July, Mr Lodge was sacked from the workshop and returned to E wing at 9 am. He was then located in the segregation unit, awaiting adjudication on charge 810/98, endangering health or safety by firing staples from a compressed air gun. The papers from the adjudication are no longer available and Mr Lodge's letters do not give any account of the incident giving rise to the charge. The penalty the governor imposed was seven added days suspended for one month, seven days stoppage of 100% earnings and seven days stoppage of all privileges, including:

- canteen (buying things from the prison shop)
- association (indoor recreation periods with other prisoners but not statutory exercise)
- tobacco

- publications
- radio
- occupations in cell
- possessions in cell.

7.33 Witnesses told the inquiry that during the week of punishment Mr Lodge would have retained his statutory entitlement to one hour's daily exercise outdoors with other prisoners (weather permitting). They were not able to suggest what other means of occupation would have remained for Mr Lodge without the facilities removed by the governor's punishment.

7.34 The prisoners on E wing had jobs and enhanced privileges. In history sheets entries on 25 July:

- SO Lowe recorded that Sonny Lodge was to go to standard regime on K wing for the seven days of his punishment.
- The next entry, by Officer Smyth, noted that Sonny had made a very serious suicide attempt and his F2052SH was closed recently and he should be monitored carefully and return to E wing after seven days.
- The next entry, signed by the then Coordinator for preventing suicide and self-harm, says that, after discussion with SO Lowe, Sonny Lodge would be located on H wing.

7.35 Sonny Lodge was moved to H wing instead of K wing with loss of association and all privileges for seven days. At that time H wing was the unit for prisoners on basic, the most restricted regime, to which prisoners were allocated following consistently poor behaviour.

7.36 The inquiry has not been able to establish why H wing was preferred to K wing. Mr Lowe could not remember the reason but commented that H wing held only 70 prisoners compared with 200 on K wing. SO Nuttall commented in respect of a later move that K wing was a large wing that might seem intimidating after a small prison like Risley. From HMCIP reports it appears that H wing, although an austere regime, had a healthier culture than K wing at the time (see above, paragraphs 7.13-7.19).

H wing: 25 July to 1 August

7.37 In a letter, Sonny says he was told he was going to K wing and arrived there but was then told he was moving to H. He said he did not know what was going on but at least he was only going to be there for seven days.

7.38 In another letter, on 25 July, Mr Lodge says he has been in front of the governor and now needs to *"keep his nose clean"* and promises to *"keep his head down"*. He says he hopes the staff leave him alone *"but that won't happen"*. In a letter of 25 July to his sister, Mr Lodge says he has not been getting his head down, but only because the officers have been "*pushing me around"* trying to provoke him *"because of when I assaulted that screw in outside hospital*".

7.39 Mr Lodge was on H wing from 25 July to 1 August. A history sheet entry for Sunday 26 July says that he was removed from the exercise yard for being abusive to a dog handler. Mr Lodge's version is that he *"got taken off exercise 'cos some of the lads I was with were taking the piss out of a german. Got banged up. Then two minutes later two germans come in threatening to kick fuck out of me, but nothing come of it, just got warning."* He wrote that he had been told he would be back on E wing on Friday and couldn't wait. He *was "missing his telly and his tunes"*. (In common with many prisoners, Sonny Lodge often referred to prison officers as 'germans' or 'screws'.)

The day centre manager's evidence

7.40 The manager of a day centre in Manchester that Sonny had attended was aware of his self-harm at Risley and the incident at Whiston. When she learned that he was in Manchester prison she arranged to visit. She recalled in her statement for the Inquest that this was on or about 4 August and that, after the visit, concerned for Sonny's welfare, she asked the Methodist chaplain at the prison to visit him. The chaplain recalled it as being earlier, and that she visited Sonny on about 15 July. The chaplain said she was not aware that Sonny Lodge had been on an F2052SH at Manchester and said that if she had known that he was on an open F2052SH when she visited she would have made a note in it. The day centre manager said Sonny told her that he believed his reputation for assaulting a prison officer had followed him. She said Sonny told her that when he arrived at Manchester an officer told him that if he did not behave he would be *"bounced off all four walls"*.

K wing: 1 - 19 August

7.41 Officer Smyth's entry in the history sheets referred explicitly to Sonny Lodge's history of self-harm and cautioned that he should return to E wing after the seven days period of punishment. Despite this, on 1 August, Mr Lodge was moved not to E wing but K wing. The inquiry has not been able to discover why. K wing operated the standard level of regime and was the wing to which prisoners usually moved after a period on the restricted 'basic' regime on H wing. However, Sonny Lodge had not been downgraded to the basic regime. He had been located there, exceptionally, to serve a period of punishment for a single offence.

7.42 From his letters, Sonny Lodge was not happy to be on K wing. On Sunday 2 August he wrote from there that he had been *"stitched up again"*.

7.43 Thursday 6 August was Sonny's 28th birthday.

7.44 On Friday 7 August, Mr Lodge wrote to his sister that he did not know how long he would be on K wing but it was *"doing his head in"*. He was waiting for the police to come and charge him about the Whiston incident, though he expected the charge to be *"laughed out".* He said he had been in jail six times and this was his first 'nicking'. He called it a *"stitch-up".*

Loss of association

7.45 Entries in Sonny Lodge's history sheets record loss of association on K wing under the wing-based disciplinary system on 10, 16 and 18 August. From a letter, it appears he may also have been locked up during association on 17 August.

7.46 An entry in the history sheet for Monday 10 August by Officer Hughes records loss of association for shouting out of the window. There is an unsigned entry dated (Wednesday) 12 August that says Mr Lodge was caught in another person's cell without authorisation and informed that the next entry would result in an incentives board and transfer to H wing, to which Mr Lodge was said to have replied, *"So what. It's a piece of cake there."* This entry appears out of sequence after an entry for Monday 17 August.

7.47 In a letter on Friday 14 August, Mr Lodge says he has been *"stitched".* He does not explain the circumstances, which he had apparently told his girlfriend about on the phone that morning. He is unhappy still to be on K wing which he says again is "*doing his head in".*

7.48 On Sunday 16 August, an entry by Officer Brady records loss of association for swinging lines - passing contraband between cells via the windows. Mr Lodge writes to his girlfriend that he has been nicked again because his padmate has thrown a line so he will not be able to phone her. He calls the wing "*a stitch-up"* that is doing his head in, and any more and he'll snap in a big way. He says he had been waiting to speak to his girlfriend, his *"head is battered"* because he can't, and that he will telephone on Monday if he is not *"stitched up again".* He says he wonders what he will be stitched up for next and that he knew he would get stitched up *"as soon as that screw gave me loads about that nicking in Risley"* and that the officer *"said he knew that I was on a suspended and he would get me on it."* He also said he thought the staff were holding back his mail because a letter from his girlfriend seemed to have been delayed.

7.49 An entry by Officer Harold on 17 August records loss of association for Tuesday 18 August for swinging a line. On Monday 17 August, Mr Lodge wrote that he was sorry about not being able to telephone on Sunday or Monday because he got nicked again. He hoped to ring on Tuesday morning. He said he was sorry about getting nicked but was being *"stitched up something chronic".*

7.50 On 18 August, SO Nuttall recorded in the history sheet that he recommended a cell move and that Mr Lodge should be placed on report if there were any further entries. SO Nuttall told the inquiry his impression that Mr Lodge felt a small fish in a large pond on K wing and that a move to another wing would be beneficial: He said he recalled speaking to him and "*we did sit and talk about moving him off the wing"*. SO Nuttall said that Manchester was a very old traditional jail and the whole scale of the establishment was very different from Risley. In particular, he commented that K wing held over 200 prisoners whereas Risley prison would have held only about 400 prisoners in total so to have as many as half that number on a single wing could be intimidating.

7.51 In a letter at the time, Sonny Lodge that he had been moved to another cell and been in front of the Senior Officer who warned him that one more loss of association would mean he would serve the seven added days so he was *"keeping his head down".* He said he was sorry he couldn't ring on Sunday, Monday or Tuesday because his padmate got him nicked again for throwing lines. He also said that he had only just received his girlfriend's letter written a week earlier and he believed staff were holding his mail back.

7.52 The Prison Service investigators spoke to the resident Listener on K wing. Listeners provided a confidential peer support scheme modelled on the Samaritans and supervised by them. The K wing Listener said he had seen Sonny Lodge on his reception on the wing and given him a card about the Listeners. Otherwise he just met him on the landing and he seemed a *"bouncy cheerful type".*

H wing then G wing

7.53 On 19 August Sonny Lodge was moved to H wing. The reason is not recorded. On 21 August he was taken to B wing in the Bottom Prison but he recognised a prisoner who was said to have assaulted his girlfriend so to avoid trouble he was moved to another wing instead. This was G wing, back in the Top Prison.

7.54 Mr Gray shared cell G3-24 with Sonny Lodge. Mr Gray said he asked for Mr Lodge to be put in his cell as they were friends outside. He told the Prison Service investigators Sonny Lodge was always getting abuse from the officers. In oral evidence to the inquest, Mr Gray said that during the week he and Sonny Lodge shared a cell on G wing he was aware of officers getting at Mr Lodge.

7.55 Sonny Lodge reportedly told Officer Cowley, Officer Shaw and Father McCann that he expected something to be planted during the cell search on 27 August.

Chapter 8:

SUNDAY 23 AUGUST TO THE MORNING OF THURSDAY 27 AUGUST

Summary

8.1 During this period, Mr Lodge was based on G wing. He was taken to Huyton police station where he was charged with grievous bodily harm on Officer Brownley as a result of the incident at Whiston and was remanded in custody until 8 September. Unless he could get bail he would not be released on 28 August as expected. His girlfriend was concerned for his safety and telephoned the prison twice. Two officers and two chaplains concluded that Mr Lodge was not at risk of self-harm and that there was no reason to open an F2052SH.

Sunday 23 August: Ms A visits

8.2 On Sunday 23 August, Sonny's girlfriend visited him in Manchester prison for the first time.

Monday 24 August: Charged with grievous bodily harm

8.3 On Monday 24 August, Mr Lodge was taken to Huyton police station where he gave a statement and was charged with grievous bodily harm on Officer Brownley. Mr Lodge's legal representative told the inquiry that the scarring from when he cut his arms in June was quite horrific and she recalled saying on tape during the police interview that the injuries were still very evident. He was remanded in custody by the magistrates' court next day, Tuesday 25 August. He made a further application for bail which a judge in chambers would decide on Friday 28 August. Forms completed by police and prison officers transferring custody recorded that Sonny Lodge had a history of attempted suicide and might have suicidal tendencies.

Tuesday 25 August: Ms A's telephone call

8.4 Mr Lodge's girlfriend, Ms A, said in her witness statement for the Coroner that she spoke to Mr Lodge's legal representative, who told her he was *"a bit down"*. Ms A was worried Mr Lodge might hurt himself again so she telephoned the prison. She told the woman she spoke to she was worried about her boyfriend who *"was a self-harmer"*. The woman told her not to worry and that she would get someone to check on Mr Lodge.

Healthcare officer

8.5 An entry in Mr Lodge's Inmate Medical Record by Healthcare Officer Stell says he interviewed Mr Lodge at 6.30 pm following a message that his girlfriend had telephoned to say *"she was worried about the possibility of him self-harming on return to prison".* The entry says that Mr Lodge said he was a little upset when refused bail but now felt OK about returning to prison. He had been asked to inform wing staff if he felt he needed to talk to someone and no follow-up was required.

8.6 HCO Stell was working in reception seeing prisoners newly admitted to the prison. One of the auxiliary staff gave him the message. He went to the holding room and asked Mr Lodge to come into the corridor. (In a letter of 8 August 2009, Mr Stell told the inquiry he would have done his utmost to ensure the conversation was as far away from others as possible, though it was difficult to have complete privacy, given the physical as well as operational constraints of the prison, including security.) Mr Stell asked Sonny Lodge if he was all right or if he had any problems and explained that his girlfriend had telephoned, concerned about his health, and asked staff to keep an eye on him. Mr Stell said he asked Mr Lodge whether he had given Ms A any indication something was wrong and that Mr Lodge replied that he had been upset and annoyed when he did not get bail and *"flew off the handle a bit".* Mr Stell said Mr Lodge's manner was quite jovial; he said he was quite OK and everyone had *"got the wrong end of the stick"*. He gave HCO Stell no indication at all that he might self-harm. HCO Stell said he assured Mr Lodge that he or other health care staff would be available if he needed to speak to someone and Mr Lodge assured HCO Stell that if he needed to see somebody he would ask. HCO Stell said he did not know that Sonny Lodge had a history of self-harm.

8.7 HCO Stell explained to the Prison Service investigation that Mr Lodge's medical record would not have been available in reception. In his recent letter, Mr Stell told the inquiry that he would probably have made notes during the conversation then completed the entry in the Continuous Medical Record when he returned to the healthcare centre before going off duty that evening. He said that a prisoner returning from court would not usually see a healthcare officer. He saw Sonny only because of the telephone call. He did not see the escort record or Sonny Lodge's prison file and did not know his history of self-harm.

Wing officer

8.8 Officer Sanderson in the G wing office also received word of Ms A's telephone call, from a Principal Officer. At 6.45 pm he made a note in the wing observation book to alert staff that a message from a relative said that Mr Lodge was not going to be released on Friday as he expected and might commit self-harm *"as he has a history of self-harm".*

8.9 Officer Sanderson spoke to Mr Lodge when he came to the wing office to book in and collect his canteen. Officer Sanderson told the Prison Service investigators that Mr Lodge knew he would not be released on the Friday and seemed *"happy with the situation".* He said he was OK and seemed not to want to prolong the conversation. Officer Sanderson told Mr Lodge that a relative had been in touch with the prison and would like him to get in touch. The conversation was *"on a light note".* In a letter of 8 August 2009, Mr Sanderson told the inquiry there were no other staff in the wing office at the time. From Mr Lodge's demeanour, Officer Sanderson gained no sense that there was any reason to take him elsewhere to talk more privately. Officer Sanderson said he had no prior knowledge of Mr Lodge's history of self-harm. According to the Coroner's note of oral evidence at the inquest, Officer Sanderson said he had asked Mr Lodge about scars on his arms, which Mr Lodge said were caused by a motorbike accident.

8.10 After the conversation at the wing office, Officer Sanderson made a note in the wing observation book that he had spoken to Mr Lodge who stated that he knew he would not be released on Friday, everything was all right, he felt OK and said he was happy with the situation. Officer Sanderson did not refer to Mr Lodge's history sheets or make any note in them.

Mr Lodge's letter on Tuesday evening

8.11 Sonny Lodge's letter that evening after lock-up shows that he was taken aback to have been charged with grievous bodily harm rather than a less serious offence. The letter starts positively: it only means another six to eight weeks and his *"head is right"* as long as his girlfriend is still there for him. But he then says that it might be six to eight months, and that he cannot ask his girlfriend to wait unless she wants to. His mood darkens, saying that without her, *"the … shadowlands will be calling and I will be at peace with my maker"*, like his mum and dad, who went *"to the shadowlands before I even knew what a mum and dad was".* He is very upset about what Officer Brownley has

said about him and protests that he is not guilty. He says he has been *"grassed up bigtime"* before *"but never stitched up like this".*

Wednesday 26 August: Ms A telephones again

8.12 Ms A telephoned the prison again on Wednesday and left a message on the chaplain's answerphone. She would not have received Sonny's letter from Tuesday evening at that point. The message was picked up by Ms Lorimer, who was duty chaplain for the day.

8.13 Ms Lorimer had come across Sonny Lodge before. She was Chair of a day centre he had sometimes attended in Manchester and said she knew him vaguely by sight. When Mr Lodge was in Manchester prison, the manager of the day centre, Ms Stanway, visited him and asked Ms Lorimer to visit in her capacity as an assistant chaplain. Ms Lorimer said Ms Stanway felt that Sonny Lodge was suicidal after the hospital incident. Ms Stanway said she visited him on or about 4 August and this prompted her to ask Ms Lorimer to see him. A letter from Mr Lodge refers to Ms Stanway visiting on 5 August. However, Ms Lorimer told the inquest that her diary indicated she visited Mr Lodge on 15 July.

8.14 Ms Lorimer has recently provided additional information at the inquiry's request. She said that when she visited Mr Lodge on this first occasion she was aware from Ms Stanway that he had previously self-harmed but not that he had attempted suicide. They had a conversation of about 12 minutes. Mr Lodge did not want to talk longer. He appeared resigned to serving his sentence. His mood seemed flat but he made no reference to being suicidal or to any bullying or violence and he did not talk about the incident with the officer. Ms Lorimer said she did not try to force him to discuss matters he was not ready to disclose. She was a trained and experienced counsellor and commented that it was a principle of counselling that, whilst recognising the need to identify risk, it is important to respect an individual's need for privacy. Ms Lorimer said she did not check at the time whether there was an open F2052SH for Mr Lodge. If she had known that there was an F2052SH she would have made a note in it. At the inquest, Ms Lorimer said she was not aware that Mr Lodge had been on F2052SH at Manchester.

8.15 Ms Lorimer recalled that in reply to the message on 26 August she telephoned Ms A who told her that Mr Lodge was depressed and low and wanted one of the

chaplains to see him. Ms Lorimer told the inquiry that she cannot now remember the detail of the conversation and it was not clear from the statements she made closer to the time whether Ms A warned specifically about suicide or previous self-harm. She recalled that she went to see Mr Lodge immediately, to have a reasonable length of time before she would have to leave the wing at lock-up. Ms Lorimer spent 40 minutes with Mr Lodge on G wing, leaving him about 11.50 am just before prisoners were locked in their cells before lunch. Ms Lorimer found Mr Lodge *"very down and low"* and he wanted to see her. They talked in the room on G wing that was sometimes known as the chapel. Sonny talked mainly about the incident with the Risley officer and his *"worst concern"* that he was going to be gate arrested on his release day because of it. Ms Lorimer understood from Mr Lodge that a governor had found there was no case to answer but the officer had taken a private prosecution. Mr Lodge felt upset and depressed because of a sense of real injustice. Ms Lorimer told the inquiry it was the injustice that really rankled with him. Ms Lorimer asked Mr Lodge whether he would like her to take it up at an official level, for example, by speaking to a governor but he said he did not want her to do anything. He wanted to *"keep his head down."* He believed that staff on G wing did not know about the Risley incident.

8.16 Ms Lorimer said that Mr Lodge also talked about the incident when he severely cut himself and of trying to commit suicide. She said he linked these feelings to being unable to cope with the death of a six year old son. He had expressed despondency and pain and talked of times when he had slashed his arms for relief. He said he was feeling depressed and had thought about suicide. Ms Lorimer asked whether he had thought how he would kill himself and he said not. Ms Lorimer asked him whether he had thoughts of suicide at present and he said he had not. Ms Lorimer told the inquiry that the distinct view she formed was that his single suicide attempt had been linked to the death of a son. Ms Lorimer was a bereavement counsellor. Sonny's description of his feelings was in keeping with her experience of feelings expressed by others who had suffered bereavement. She was surprised when she heard at the inquest that Sonny was not known to have had a six year old son.

8.17 Ms Lorimer was asked by the Prison Service investigators whether she considered opening an F2052SH. She said that she was concerned about Sonny but the overriding concern on Wednesday 26 August was that he did not want to make a fuss on the wing. Ms Lorimer told the inquiry that she had asked if he had thought how he might

commit suicide and he said no. She decided to keep her concerns within the chaplains' team. At the end of the conversation she told Sonny that a chaplain would visit him the next day so he was aware that support was continuing.

8.18 Ms Lorimer told the inquest that when she left Sonny Lodge she did not think he was at risk of self-harm. In her recent statement to the inquiry, Ms Lorimer said that the confidence she was keeping was Sonny's feelings of injustice, not any feelings of self-harm. If she had thought there was a sufficient self-harm risk she would have shared that with the discipline staff through the F2052SH process. She knew how to open an F2052SH and frequently did so and she had gone to see Sonny Lodge with an open mind, trying to offer support and help. Mr Lodge's concern was about being re-arrested on release, not about events at Manchester. He said he was not under any pressure on the wing. He had a sense of injustice about the Risley officer apparently taking a private prosecution. He expressed emotion about the death of a son.

8.19 Back in the chaplains' office, Ms Lorimer arranged for Church Army Captain Palmer, to visit Mr Lodge next day, when he would be duty chaplain. Mr Johnson, the coordinating chaplain, was also in the office at the time. Ms Lorimer recalled that she talked to her colleagues about how depressed Mr Lodge was and about his concern about the Risley incident and desire to remain anonymous on G wing. She told the inquiry that the chaplains were a close-knit team and shared information in a variety of ways. The emphasis was on oral handovers but at some point a pastoral book and blue files were introduced in which they highlighted concerns. Ms Lorimer could not recall when they were introduced but she said that the fact that no papers had come to light about Sonny might suggest they were not in use at the time. For herself, Ms Lorimer kept notes in a diary. The Chaplain's Journal recorded statistics, formal applications and actions taken as part of the chaplains' statutory duties. Mr Johnson told the inquiry the pastoral book was introduced later but was not widely used. He believed the blue files must have been introduced after he left the Prison Service in July 2001.

Wednesday evening

8.20 On Wednesday 26 August, Mr Lodge wrote to his girlfriend that he did not expect bail from the application his solicitor had made to a judge in chambers. He says he is *"as good as hanged so it means another six to eight weeks"* and then he hopes he will be home "*where I belong"*. He says his *"head is…battered"* but there is nothing he can do about it so he just has to *"get on with it again"*.

Thursday morning

8.21 Captain Palmer made a written statement for the Prison Service Investigation and made a recent statement to the inquiry in response to extracts from a draft of the report. Captain Palmer said Ms Lorimer asked him to look in on Mr Lodge who was due to be released on Friday 28 August but expected to be 'gate-arrested' in connection with an alleged assault at Risley that he denied. Captain Palmer said he saw Mr Lodge at about 10.30. He invited him out of the cell on to the landing to speak more privately out of earshot of others. He had not met Mr Lodge before so did not know his usual manner but found him morose and unresponsive. Captain Palmer attributed this to his concern about being gate-arrested. He offered further help from the chaplaincy and tried to encourage Mr Lodge to take things a step at a time. He told him Ms A would visit that afternoon, which Mr Lodge did not seem to know.

8.22 Captain Palmer told the inquiry he was asked to check on how Sonny Lodge was doing in the light of his adverse bail decision. He did not know the detail of Ms Lorimer's conversations with either Mr Lodge or his girlfriend. He was not asked specifically to consider risk of suicide and self-harm and, to the best of his recollection, did not know at the time that Sonny Lodge had a history of self-harm. Captain Palmer said he was trained in the F2052SH procedure and in counselling and had often opened an F2052SH, but there was nothing in Sonny Lodge's demeanour or overall presentation that led him to think Sonny Lodge was at risk of self-harm or to prompt a further conversation in a more private place.

Chapter 9:

THURSDAY 27 AUGUST: THE INCIDENT AFTER VISITS; THE DECISION TO SEARCH SONNY LODGE'S CELL

Summary

9.1 In the morning of Thursday 27 August, Sonny Lodge attended a discharge board. Officer Downs was the escorting officer and made an entry in his history sheets that he would not be released. As a result of an altercation with Officer Downs on the way back from a visit in the afternoon, Mr Lodge was to be locked in his cell during the association period. Officers decided to search his cell. Mr Lodge complied with the strip search. His cellmate was elsewhere on the wing at the start of the search and was not searched. No unauthorised articles were found.

The discharge board

9.2 Sonny Lodge was due to complete the custodial part of his sentence on 31 August and because of the Bank Holiday weekend he would have been released on Friday 28 August. He attended a 'discharge board' on Thursday morning. This was a meeting with a principal officer to deal with various administrative procedures. Because Sonny Lodge had been remanded in custody on the charge of assaulting Officer Brownley, he would not be released, though his status would change from sentenced to remand prisoner. Officer Downs escorted Mr Lodge and some other prisoners to the discharge meeting and waited outside the office where the meeting was held. Officer Downs could not recall how many prisoners were in the group. When he came back to the wing he made an entry in Sonny Lodge's history sheet that he had attended a discharge board but was "*NFR",* meaning not for release.

9.3 Officer Downs told the inquiry that he did not know Sonny Lodge or why he would not be released. He had just returned to work after 11 days' leave and Mr Lodge made no particular impression on him.

The incident on the way back from visits

9.4 In the afternoon of Thursday 27 August, Mr Lodge's girlfriend visited him with her young niece and a friend. She told the Coroner's officer the visit ended normally. As Mr Lodge was returning to G wing after the visit, there was an altercation with Officer Downs.

9.5 Officer Downs told the inquiry that he was the last officer to leave visits. He had to make sure all the prisoners were out and escorted back to their wings. He needed to keep a large group of prisoners in sight and together. Mr Lodge and another man were lagging behind the main body of prisoners and talking. He told them to move on and says that Mr Lodge swore at him, first directly, then muttering, abusively. Mr Downs told the inquiry that Mr Lodge was aggressive in tone and manner and that he spoke with venom.

Loss of association

9.6 Officer Downs says that, back at G wing at about 5 pm, he challenged Mr Lodge about the incident and he denied all knowledge of it. Officer Downs instructed that he would lose association for the evening. Under the wing-based disciplinary system operating at the prison at the time, prison officers were able to impose certain sanctions, including loss of association, for minor infringements of the rules, provided they were approved by a senior officer. The scheme had been criticised by the Prisons Inspectorate – see Chapter 7 above. Officer Downs told the inquiry that the senior officer (SO) for the afternoon shift was present when he challenged Mr Lodge so it was not necessary expressly to seek approval. He said that if the SO thought it inappropriate he or she would have said so.

9.7 Officer Downs said he did not recall who the senior officer on duty was. A note from the Central Resource Unit dated 9 September 1998 says that SO Frazer was on duty on G wing from 07:00 to 13:00 and SO Nuttall was the SO on the wing from 13:00 to 21:00. However, that appears to be incorrect. SO Nuttall told the Coroner's officer that he came on duty at 17:30 and was in charge of the wing for the evening shift. In his evidence to the inquiry, SO Nuttall said that he was not aware of the incident on the way back from visits as he took over responsibility for G wing at about 18:00 hours. He assumed that the SO responsible for the wing during the core day of 9 to 5 would have dealt with it.

The records

9.8 The system required sanctions to be recorded in a loss of facilities record signed by the authorising SO and in the prisoner's history sheets. There was no entry in the loss of facilities record. Officer Downs told the inquiry this was an oversight, possibly because of the incident that occurred later. He said he would have completed the paperwork in

the course of the evening but, because of what happened later, he was distracted from doing so and did not want to complete the record retrospectively when next he was on duty. Immediately after seeing Mr Lodge he had gone about his wing duties, helping with locking prisoners up and checking the roll. He had taken his tea-break then helped with unlocking prisoners for tea.

9.9 Mr Downs made the following entry in Mr Lodge's history sheets:

"Whilst escorting this inmate from visits he stated 'you're on fucking top man' and 'fucking screw'. When confronted on the wing later he denied any knowledge despite this having been witnessed by Officer Dean. Warned re his attitude but just laughed. LOA x 1. Incentive Board referral started."

LOA means loss of association.

9.10 Mr Downs omitted to sign the entry. It immediately followed his signed entry about the discharge board. Officer Downs said he may have been confused by that. He was talking to Officer Bowcock while making the entry and might have seen his signature above and assumed he had signed.

Officer Dean's evidence

9.11 Officer Dean told the Prison Service investigation that Sonny Lodge initially went with the group going towards the Bottom Jail (wings A to E) instead of the group going toward the Top Jail (wings G, H, I and K). Mr Downs asked him to move to the right queue. At first Mr Lodge ignored Officer Downs. When asked again to move, Mr Lodge "*tutted to himself"* and acted as if he "*just didn't car*e". Officer Dean said Mr Lodge was abusive but he could not remember him swearing.

Sonny Lodge's account

9.12 According to the summary record of the adjudication next day, Mr Lodge said he was pulled in front of the SO and accused of telling an officer to *"fuck off"*, then taken to his cell, where he stayed for about an hour before being unlocked for tea. He got his tea and was locked up for about another hour and then the officers came to do a search.

Mr Gray's evidence

9.13 Mr Lodge's cellmate, Mr Gray, told the Prison Service investigators and the Coroner's officer that Mr Lodge was *"low"* when he came back from visits and was holding his head in his hands. Mr Gray said Mr Lodge told him that officers finished his

visit before time and that there was a bit of verbal abuse between them from the visit and back to the wing. The cell was unlocked for Mr Lodge to collect tea at about 6 pm and the officer told him he was on *"bang-up"* (loss of association), to which Mr Lodge said he was not surprised. Mr Gray said the officer called to another officer about speaking to Mr Lodge about it later.

9.14 Mr Gray said that when the cell was unlocked for association, he was told that he must go out of the cell and could not stay with Mr Lodge. SO Nuttall said that if Mr Gray had wanted to give up association and stay with Mr Lodge he could do so. Mr Bowcock said in his police statement in September 1998 that it would be unusual for a prisoner to ask to stay in his cell in these circumstances but 90% of the time they would be told no. However, in oral evidence to the inquiry Mr Bowcock said that a prisoner would be within his rights to stay in his cell during association.

How cells were selected for searching

9.15 The inquiry asked how cells were selected for searching. Witnesses said that routine searching was conducted by wing officers and that all cells were searched at least once in a specified cycle. Witnesses' recollections varied as to whether at the time the cycle was one month or two. A record was kept on the wing so that searching officers could see which cells still required searching to comply with the standard. At the end of the cycle the record was passed to the security department.

9.16 SO Nuttall told the inquiry that officers detailed for searching exercised discretion about which cells to search. He said there was a degree of trust. Staff would have regard to meeting the minimum requirement, but would not search only cells that had not already been searched in the cycle. To confine searching in that way would be to undermine its purpose, if prisoners could count on their cells not being searched more than once in a cycle. Governor McColm said the pattern must always be random. In addition to routine searching by wing officers, targeted searches were undertaken by the prison's dedicated search team where security information gave rise to particular suspicion.

G wing search records

9.17 The records for the searching cycle showed that on 27 August all the cells on G wing had been searched at least once in July or August. Sonny Lodge's cell, G3.24, had been searched on 12 August 1998. An 'excess searching sheet' recorded cells that were

searched a second time within the searching period. Before 27 August, the most recent 'excess' search was on 31 July. An 'excess' search of Cell G3-24 was conducted on 27 August. The form records that Officers Plane and Bowcock conducted 'excess' searches of a further five cells the following day.

The decision to search Mr Lodge's cell

9.18 Officer Downs and Officer Bowcock have explained that they were detailed as Wing Patrol/Search officers for the evening. Officer Bowcock said in his statement to the police that he was in charge of the search book as he had worked in the Dedicated Search Team. Officer Downs says that he was making the entry in Mr Lodge's history sheets about the altercation in the afternoon when Officer Bowcock spoke to him about which cells to search that evening. There were adverse entries on the opposite page of the record (the third page of the history sheets), with two references to swinging lines and one saying that Mr Lodge had been caught unauthorised in another person's cell. These, coupled with Mr Lodge's demeanour earlier and the fact that he had had a visit at which he might have been passed something, led Mr Downs to consider that he might have something to hide. The two officers agreed that this marked him out as an appropriate candidate for a cell search.

9.19 The first and second pages of the history sheets contained, respectively, the entry on 17 July about the alleged assault on Officer Brownley and the entry on 25 July saying that Mr Lodge had made a serious suicide attempt and his F2052SH had just been closed.

Mr Downs' evidence

9.20 According to the governor's record of the adjudication on 28 August 1998, Mr Downs said that they decided to search Mr Lodge because of entries in his record.

9.21 In his statement to the police in September 1998 he said that he spoke to Mr Bowcock about what he had just been reading in Mr Lodge's record and Mr Bowcock suggested they search his cell.

9.22 At the disciplinary interview in September 1999 Officer Downs said that Officer Bowcock had told him that entries in the observation book made Sonny Lodge a likely target and they consulted the SO who agreed. The observation book was for staff to alert colleagues to significant events on the wing. It was not part of a prisoner's personal record. Mr Downs told the inquiry that at the time of the disciplinary interview he had little

recollection of the incident and must have been mistaken about the observation book. He confirmed to the inquiry that he specifically recalled that the officers had told SO Nuttall that they wanted to search a particular prisoner because his demeanour and the entries in his record indicated that he might have something to hide.

9.23 According to the Coroner's notes of oral evidence to the inquest in July 2001, Mr Downs said he had read Mr Lodge's wing history sheets but could not say whether they showed he had been on F2052SH or was alleged to have assaulted an officer. He said he did not check the observation log.

9.24 In his statement to the inquiry, Mr Downs said that he was not aware that Mr Lodge was facing a criminal charge of assaulting a Risley prison officer and he had not noticed the entry in the history sheets about this that was subsequently brought to his attention.

9.25 In oral evidence to the inquiry, Mr Downs said that when he had been making the entry about what happened coming back from visits, which *"seemed completely out of the blue"*, he had wondered if anything similar had happened before so he *"had a quick précis through a page or two back to … see if there was any sort of pattern of any sort of behaviour that would establish why he'd been like he had and I saw the entries reference swinging lines and being in the cell he wasn't supposed to be, and then put that together with the fact that he'd been very standoffish after a visit and, you could call it assumption, but you have to work on hunches and your sixth senses, if you like, when you're working with that kind of level of information."*

9.26 Mr Downs went on to say that it might not have crossed his mind to search Sonny Lodge's cell that evening but for the fact that Officer Bowcock happened to approach him about where they were going to search just when he was writing in Sonny Lodge's file.

Officer Bowcock's evidence

9.27 Mr Bowcock said at the adjudication and again at a disciplinary interview in 1999 that Mr Lodge was identified as a legitimate target from the observation book.

9.28 In his statement to the police in September 1998, Mr Bowcock said that it was comments in the wing observation book that brought Mr Lodge to his attention. When it was pointed out that there were no adverse comments in the observation book, Mr Bowcock acknowledged that he had been in conversation with Mr Downs at the time,

though he was convinced that he had referred to the observation book and not Mr Lodge's personal record. He said he might also have got information from other officers. Another reason for searching Mr Lodge's cell was that he was conveniently available, being on 'bang-up' during the association period.

9.29 In oral evidence to the inquest Mr Bowcock said that he could see that Mr Lodge's cell had not been searched within the month. The records show this was incorrect.

9.30 Mr Bowcock told the inquiry that he could not be sure whether he had looked at the history sheets but his recollection was that the main reason for selecting Mr Lodge was that he had had a visit. In his statement, he said that he could *"categorically state that the entry in the record* [about an assault on Officer Brownley] *did not in any way provide the motivation for the decision to search Mr Lodge's cell. I do not remember reading that particular entry."*

SO Nuttall's evidence

9.31 SO Nuttall told the inquiry that when he came on duty in the evening staff were already detailed to particular duties and Officers Bowcock and Downs told him they would start routine cell searching. He said they did not say which cells were to be searched. He would have expected them to do so only if the search was because of security information or immediate grounds for concern such as a smell of cannabis coming from a cell.

9.32 SO Nuttall said that he did not look at the wing observation book when he took over the wing but relied on an oral handover from the outgoing senior officer to alert him to any problems.

The records

9.33 Mr Bowcock wrote the cell number, Mr Lodge's name and prison number and his own name in the excess searching sheet. He did not enter the name of Mr Lodge's cellmate, or Mr Downs' name; the entry was not signed and no result was entered. The details would normally have been completed at the end of the search. In his statement to the police, Mr Bowcock said that he did not complete the entry that evening because of the incident after the search and when he looked for the book to complete the record the next day it was gone.

9.34 Mr Bowcock was asked about the records of the five searches that he appeared to have conducted with Officer Plane the next day. He confirmed that the record was in his handwriting and could not remember why he had not completed the record for the previous day when making these entries.

Searching a two-man cell

9.35 The inquiry examined whether it was normal practice to search only one prisoner in a shared cell. Staff told us that ideally both prisoners should be searched but if one prisoner was not available that was not a reason to abandon a search. The inquiry understood that searches should be neither predictable nor avoidable, by prisoners making themselves scarce when officers were ready to search.

9.36 In his police statement, Mr Bowcock said that sometimes you would search only one occupant of a cell if the other was difficult to get hold of. He could not recall why he had not written the cellmate's name on the form. He thought it was possibly because the name was not on the board in the office or because Mr Lodge was on 'bang-up'. He agreed it was the usual procedure to include both occupants in the search. He said it was pointless to call the cellmate to the cell since if he had contraband in his possession he could have got rid of it.

9.37 Mr Downs told the inquiry they intended to search both prisoners and called for the cellmate but it was during association and he did not answer to any calls. There was no loudspeaker system on the wing. There were many places he might be to avoid being found. It was not necessary for both prisoners to be present and at that time cells were sometimes searched without either occupant being present or searched.

9.38 SO Nuttall said in his statement to the inquiry that if the other prisoner was not available at the time of a proposed cell search it was not inappropriate to search only one prisoner in a shared cell.

9.39 Mr Gray told the Prison Service investigators that during the search he went to his cell and the officers told him to go away. In his statement to the police, Mr Bowcock said that a prisoner came to the door and asked what they were doing then walked away. Mr Bowcock said he did not know Mr Gray. He said he probably would not have been aware that he was the other occupant of the cell and, in any event, by then they were well into the search.

The search

9.40 The cell search consists of a full body (strip) search of the occupant of the cell and then a search of the prisoner's property and the furniture and fabric of the cell. Officers Bowcock and Downs both confirmed that Mr Lodge complied with the strip search without difficulty. Officer Downs said he was *"dismissive"*. Officer Downs and Officer Bowcock both told the inquiry that they had no recollection of seeing the scars on Mr Lodge's arms that his legal representative and Officer Sanderson had both noticed that week. Officer Bowcock said he might have been more concerned with searching Mr Lodge's clothes than looking at his arms.

Chapter 10:

AFTER THE SEARCH: THE INCIDENT IN THE CELL

Summary

10.1 When Mr Lodge came back to the cell Mr Bowcock drew his attention to the local prison rules which he had put on the cell noticeboard and highlighted with a red pen. An incident occurred. Mr Lodge was restrained and charged under the statutory Prison Rules with attempted assault. He was taken to the health centre then held in the segregation unit overnight. At the adjudication next day, Mr Lodge made a counter-allegation that Officer Bowcock had lunged at him. Governor McColm found the charge against Mr Lodge proved.

10.2 The inquiry obtained information from the personnel records of Officer Downs and Officer Bowcock and has seen a High Court judgment that names Officer Downs.

The condition of the cell after the search

10.3 No unauthorised articles were found in the search. According to the evidence Mr Lodge gave at the adjudication next day the cell was in a mess. .Mr Gray, the other occupant of the cell, gave evidence to the Prison Service and the inquest that bedding and property in the cupboard had been tipped upside down, that photographs and some mail had been ripped up and the rules stuck on the board, with toothpaste, where the photographs had been, with the rule about not abusing staff ringed in red with arrows pointing at it.

10.4 Officer Downs told the inquest that they did not remake the bed but they did not leave the cell in a mess. In his statement to the inquiry, Officer Bowcock said that he and Officer Downs would have tried their best to return things to their original places. It would not have been possible to return the cell to the exact state that they found it in but they certainly did not turn the contents of the cell over and it was not in a mess.

10.5 At a preliminary meeting before the inquiry was commissioned Sonny Lodge's sister told the Chair of the inquiry that after Sonny's death the prison returned two photographs to the mother of Sonny's children. They had plaster on the back as if they had been stuck on a wall and were in good condition.

The ringing of the rules

10.6 Officer Downs said that Officer Bowcock had put up the rules. They had not discussed it but Officer Downs said, *"It was part of our job to make the prisoners conform to the wing rules and it was appropriate in this instance to bring the rules to the attention of Mr Lodge."*

10.7 When the police officers asked Mr Bowcock why he had thought it necessary to pin the marked rules on the noticeboard before Sonny Lodge returned to the cell, Officer Bowcock said that from entries in what he thought was the observation book, or possibly his conversation with Officer Downs, he had an idea that Mr Lodge was not a *"model prisoner".*

10.8 In his statement to the inquiry, Officer Bowcock said he *"decided that it would be a good idea to draw Mr Lodge's attention to this rule [about not abusing officers] because…I understood that Mr Lodge had at times shown a negative attitude to prison staff."* Officer Bowcock said it was his decision alone. When Mr Lodge came back to the cell he seemed *"surly and incoherent. I then alluded to the Prison Rules and showed Mr Lodge that I had placed them on his noticeboard for his attention. Prison Rules are supposed to be exhibited in every cell. I explained to Mr Lodge that it would be a good idea … if he were to try to keep his head down and stay out of trouble."*

10.9 In oral evidence to the inquiry, Mr Bowcock said that he did not remember whether pinning up the rules like that was something he had done before. He said he could not remember and he did not remember thinking about it at the time but *"in retrospect, with hindsight, maybe it wasn't excellent practice."*

10.10 Mr Bowcock said in his police statement that in his experience prisoners frequently claimed they were being victimised. If all the cells had been searched and there was a week left in the searching cycle then somebody would be searched twice and *"every time"* prisoners complained that *"you're getting at them".* Mr Bowcock said that he understood that prisoners resented searches *"because once they're in prison the cell is their home."*

10.11 Mr Bowcock told the inquiry that *"It's quite common for the job I was in for people to hate you. And maybe they didn't hate me … they hated the uniform more than the person inside it."* Mr Bowcock felt that prison officers *were "easy targets, there was a lot of resentment, anger, maybe."* Prisoners had *"been out on the streets two weeks ago*

and now they're doing three years and we're very easy people to vent their anger on. It was the *"nature of the job".*

The alleged assault

Mr Bowcock's account

10.12 In his written report to the adjudicating governor Mr Bowcock said that Mr Lodge returned to his cell and *"I began to explain the rules and regulations pertaining to him during his stay on G wing. At this point he became agitated and lunged at me attempting to assault me."*

10.13 According to the governor's note of the adjudication, Mr Bowcock confirmed in oral evidence that Mr Lodge moved towards him. The governor asked if this was in a threatening manner. The record says Mr Bowcock replied, *"Yes, he raised his arms."* In reply to the governor's question, he confirmed that he thought Mr Lodge was going to assault him.

10.14 In his statement to the police and at the inquest Officer Bowcock said that Mr Lodge appeared aggressive on his return to the cell and was mumbling something. The officers explained they had found nothing, but his attitude was wrong and he should *"keep his head down".* He said this *"was a standard speech I would say to any prisoner."* Officer Bowcock said Mr Lodge appeared to believe he was being victimised but this was not the case.

10.15 Officer Bowcock said he started to tell Mr Lodge about the rules which he had pinned on the noticeboard. Mr Lodge lunged. He was close to Officer Bowcock and raised his arm to him. Officer Bowcock said he stepped aside and pushed Mr Lodge into the corner of the cell and grabbed his arm. A violent struggle followed. Officer Downs asked for the alarm to be raised and came to assist. They managed to get Mr Lodge on the floor where he went limp, passive but awake. Other staff soon arrived and took over. Officer Bowcock and Officer Downs left the cell. Officer Bowcock denied hitting or lunging at Mr Lodge and denied ripping up photographs.

10.16 Mr Bowcock told the inquiry that when Mr Lodge returned to the cell his whole demeanour had changed and he was agitated. He said Mr Lodge was in the corner of the cell by the toilet and made a movement towards him so that it seemed that if he had not moved out of the way Mr Lodge would have barged past as if he wasn't there. Mr

Bowcock said he attempted to restrain him. Mr Lodge had become passive very quickly. Mr Bowcock said neither he nor Mr Downs had landed any blows on Mr Lodge.

Mr Downs' evidence

10.17 In his written statement for the adjudication, Officer Downs said that the incident occurred as a result of Mr Lodge complaining that the cell was in a mess. When he was told that he needed to have a re-read of the wing rules he became agitated and lunged at Officer Bowcock. After a struggle in the cell Mr Lodge was restrained.

10.18 According to the governor's note of the adjudication, Officer Downs said Mr Lodge was agitated when he came back to the cell. He walked into the cell and shook his head. Officer Bowcock pointed out his attitude and referred him to the rules. Officer Downs was standing at the door ready to go. At this point Mr Lodge made a grab for Officer Bowcock. The governor asked whether Mr Lodge raised his hand. Officer Downs replied, *"They were towards the officer."* The governor asked whether Mr Lodge moved towards Officer Bowcock. Officer Downs confirmed that he did. The governor asked whether Officer Downs interpreted the move as threatening. Officer Downs said that he asked Officer Cowley to press the alarm bell and went to Officer Bowcock's assistance.

10.19 In his statement to the police, Officer Downs said that on his return to the cell Mr Lodge appeared agitated and was shaking his head and *"tutting".* He entered the cell and stood in the middle with Officer Bowcock by the cell window at the back and Officer Downs towards the cell door. Officer Bowcock explained that nothing was found but that Mr Lodge's attitude needed addressing and that if he acted like an adult he would be treated like an adult on the wing. He referred Mr Lodge to the rules. Officer Downs said he did not recall whether they were circled in red. Officer Downs said that while he was taking the main lock off the door, Mr Lodge lunged towards Officer Bowcock with his arms raised. Officer Downs was unsure how Officer Bowcock fended him off. Officer Downs took Mr Lodge's left arm as his right was underneath him towards Officer Bowcock. They placed Mr Lodge face down on the floor.

10.20 In oral evidence to the inquiry, Mr Downs said he recalled that he was standing at the cell door. The search had been concluded. He had put his key into the lock and was taking the lock off when he heard a shout and saw Mr Bowcock and Mr Lodge going forward into the corner of the cell and then there was grappling and holding on. He saw contact between the two but did not see Mr Lodge hit Mr Bowcock.

Mr Lodge's account of the incident

10.21 According to the governor's notes of the adjudication, Mr Lodge said his property was *"everywhere"* and he was upset but laughed; Officer Bowcock then lunged at him; he *"tried to roll up in to a ball";* he lost consciousness then came round. He maintained that he did not raise a hand to any of the officers nor move towards the staff.

10.22 Father McCann saw Mr Lodge in the segregation unit before the adjudication. In evidence to the Prison Service investigation he said Mr Lodge told him that he expected something to be planted in the cell during the search and afterwards a confrontation occurred, triggered by his nervous laugh when he was upset by the state of his property in the cell after the search.

10.23 In evidence to the Prison Service investigation Father McCann said Mr Lodge claimed that a 'scouser' officer hit him in the face saying, "*This is for Mr…* [a name that Father McCann could not remember during the investigation interview but understood to be the name of the Risley officer Mr Lodge was alleged to have assaulted]."

Evidence given by prisoners

10.24 Two prisoners gave evidence about the incident in the cell to the Prison Service investigation and to the inquest. The inquiry tried to trace the two former prisoners from Prison Service records but was unable to contact them.

The evidence of Mr Gray

10.25 Mr Lodge's cellmate, Mr Gray, gave evidence to the Prison Service investigation and the inquest that he was able to see into cell G3-24 from G3-03 opposite. He named the officers in the cell as *"Collier"* and *"Lawson"* but told the inquest he might have got the names wrong. There is no evidence that officers by those names were on G wing that evening.

10.26 Mr Gray told the Prison Service investigators that the cell door was half-open and he could see Sonny Lodge at the end of the cell near the pipes facing the sink. *"Mr Collier"* went into the cell. Mr Gray said he could not say if *"Mr Collier"* grabbed or punched Sonny Lodge but Mr Lodge fell back and hit the floor. Then the door was closed.

10.27 Mr Gray told the coroner's officer that Officers *"Collier"*, *"Lawson"* and another were in the cell with Mr Lodge. *"Mr Collier"* was standing near the table with his back to

Mr Lodge then turned and swung his left arm toward Sonny's face and he saw *"Mr Collier"* seem to strike Mr Lodge, who was on the floor and whom he heard screaming.

The evidence of Mr Davies

10.28 A prisoner, Mr Davies, told the Prison Service investigation that he was walking upstairs to the right of cell G3-24 when he heard a commotion and looked down and saw Mr Lodge standing in the middle of the cell, smiling. Mr Gray was opposite the cell. There were a couple of officers. One walked into the cell and was rubbing his face then threw a blow. He described him as a youngish-looking officer with mousey hair and blue eyes. Then the other officer went into the cell. Mr Davies said he could see Sonny Lodge on the floor. The officer was crouching over him and looking worried. Then the door was kicked shut.

10.29 In his statements for the Prison Service investigation and the Coroner, Mr Davies said that there were two prison officers in the cells, both moving towards the door. The officer who was ahead was standing almost outside the cell. The other officer turned back to face Sonny. He said that that this officer swung his keys then put them in his pocket, raised his hands and rubbed his face, then brought his right hand in a clenched fist and punched Sonny in the forehead causing him to fall backwards. Mr Davies told the Prison Service investigators he did not know the officers' names. In his statement to the Coroner's officer he said that Mr Gray had told him later that the officer whose appearance he described was called Collier.

Evidence of the Healthcare staff

10.30 Other officers took over from Officer Downs and Officer Bowcock, who left the cell. Healthcare Officer (HCO) Williams went to G wing in response to the alarm. He told the inquest Sonny seemed to have stopped breathing. The restraints were removed and he checked for a pulse. Sonny started to breathe again as if he had been holding his breath. He then began to show signs of a fit for 5 to10 seconds. When this ended he was placed in the recovery position and his pulse checked. He was transferred to the healthcare centre. On the way he was angry and shouting at the officers, which HCO Williams thought unusual in someone recovering from a fit.

10.31 Healthcare Officer Harrison also went to the cell. He told the Prison Service investigators it was about 7.50 pm. When he arrived, Sonny Lodge was on the floor being restrained by discipline staff. He had stopped breathing once or twice and the

HCOs advised staff to loosen their hold and leave him on the floor. HCOs checked him. He seemed to have a small fit and came out of it quickly. They decided to check him in the hospital wing rather than move him straight to the segregation unit. Staff helped him to stand and he walked without restraint. During the move he saw an officer from the incident and began shouting and pointing. A nurse checked him. HCO Harrison was due off duty at 2000 and left.

10.32 Nurse Stanley told the Prison Service investigators that he saw Sonny Lodge when he arrived at the Healthcare Centre. He was fully conscious and did not complain of any injuries. His blood pressure was slightly raised and his vital signs were OK. Nurse Stanley was happy for him to walk to segregation.

10.33 In a statement for the inquest, Nurse Paterson said she was asked to check blood pressure, pulse and pupil reactions on Sonny Lodge, who was suspected to have had a fit. She found BP at 150/100 and pulse at 100 per minute, which were both a little high, and symptoms that could be expected in someone who recently had a fit. His pupil reaction was normal not sluggish but she said this reaction returns quickly after fit. Sonny Lodge said he had had a fit but could not say how long it lasted. He said he had not hurt himself. A mark on his forehead seemed to be an old graze and did not appear to need treatment.

Records of the incident

10.34 An entry in the inmate medical record states:

"Inmate C and R'd from G wing. Involved in altercation with staff. Not actually C and R'd. Staff concerned re physical response. ? Loss of conscious. When observed full recovery, not confused or post ictal. No confusion BP 150/100 P90. Transfer to seg unit. MO informed."

10.35 This entry appears immediately beneath HCO Stell's entry about Ms A's telephone call on 25 August (see paragraph 8.5 above). The date appears to have been amended from 28 to 27 August. It is not clear from the record when the entry was made or by whom. However, it appears that the entry was made before HCO Harrison went off duty. HCO Harrison told the Prison Service Investigation that his colleague, Nurse Stanley, asked HCO Williams to get Mr Lodge's medical records, that staff referred to it back in the office and Mr Stanley made the entry in the Inmate Medical Record. HCO Harrison remembered that when his colleagues were reading through it back in the office

it said Mr Lodge had a history of fitting. Mr Stanley told the inquiry that he could not remember the detail of his actions at the time.

Use of force records

10.36 No use of force forms were completed after the incident. In a memorandum of 3 September 1998 for the Prison Service Investigation, PO Hall, the prison's Control and Restraint Coordinator, confirmed that he had not received any control and restraint forms in relation to the removal of Sonny Lodge from his cell on 27 August and that these were usually received within two days of an incident.

10.37 In evidence to a disciplinary investigation, SO Nuttall said that he was told that segregation staff had said that control and restraint forms were not necessary as Mr Lodge had walked to the segregation unit.

10.38 In his statement for the police, Officer Bowcock said it was normal to do paperwork for locks or restraints but the form was usually produced to him by someone more senior. Also someone had said that Mr Lodge was not restrained so no form was needed. Officer Bowcock thought the paperwork he was required to do was the report for the adjudication.

Sonny Lodge's letter that night

10.39 Writing at around midnight on Thursday 27 August, Mr Lodge says he is starting another sentence for something *"I haven't even done"* and he is in two minds whether to *"just give up".* He says he does not know when he will be coming home, or if his head can take it. It has all gone a bit too far and *"basically they just want to hang me, so let them. I will even hand them the noose".* He says, *"They know how to rip you up real bad inside, they keep ripping something out of me every day now."* He says that can only be replaced by his girlfriend and *"I am afraid by the time comes, they will have cut off my life force and I will be gone forever."* He says that only his girlfriend has kept him going and not being able to see her on Friday, when he had expected to be released, is too painful to bear: *"They are slowly taking me away from you."*

Other relevant evidence

10.40 It is the duty of the inquiry to consider all the evidence relating the events of 27 August 1998 described in this report in order to try to form a judgment about the truth of what happened and why. Was Sonny Lodge singled out for a search as additional

punishment for the altercation in the afternoon? Was it more sinister: was he being systematically 'dug out' because of the alleged assault at Whiston? Or were officers simply doing their difficult job in a professional manner in the face of a resentful prisoner? Was it largely a matter of chance that Sonny Lodge came to their attention, first through ungracious behaviour in the afternoon and then because Officer Bowcock came to discuss searching just when Officer Downs was writing in Mr Lodge's records? Relevant evidence includes information about the professional practice of the officers involved.

The disciplinary histories of the officers involved

Officer Bowcock

10.41 There was no adverse information in Officer Bowcock's staffing records about his conduct towards prisoners.

Officer Downs

10.42 The inquiry has seen evidence from the staffing records of Mr Downs and the judgment of Moses J in the case of *Stuart Howarth v the Home Office* [HC Case No. MA 390061]. These contain information about an incident in December 2000 in which Mr Downs was alleged to have acted towards a prisoner in an unprofessional manner.

10.43 At a disciplinary hearing in June 2002, Officer Downs was found guilty of the offence that on 28 December 2000 he was inappropriately aggressive and abusive to a prisoner. The inquest into Sonny Lodge's death took place in July 2001. The disciplinary proceedings were pending at the time.

10.44 Officer Downs was dismissed as a result of the disciplinary finding. The Civil Service Appeals Board recommended that he be reinstated with a lesser penalty. According to a memo to the governing Governor on 16 July 2003, the Prison Service accepted the recommendation because Mr Downs had been allowed to continue in the same post after the offence was known, and he had no previous disciplinary record. The penalty substituted was a final written warning in force for five years, removal from the field of promotion for three years, loss of one increment. The final warning expired in June 2007 and Officer Downs was informed that his conduct over the five-year period was satisfactory.

10.45 The High Court gave judgment in February 2004 in an action for damages by the prisoner involved in the incident. The Home Office had contested the claim. The Court found as a fact that Mr Downs had taunted and abused a prisoner who he knew had suffered childhood sexual abuse, and that he had falsified an allegation against the prisoner, later withdrawing it. The judge found that his conduct amounted to harassment within the meaning of the Protection from Harassment Act 1997; the false allegation was an abuse of power; he was guilty of misfeasance in public office; and he had breached the prisoner's rights under Article 8 of the European Convention on Human Rights.

10.46 Mr Downs told the inquiry that he was not a party to the litigation, he was not asked to give evidence, he denied the allegations against him and he did not accept the finding of the disciplinary panel or the court. He said that apart from this incident and the caution for not completing forms about Sonny Lodge, his record was exemplary.

Sonny Lodge's character and credibility

10.47 Just as I said in Chapter 4 paragraph 40 about the incident at Whiston Hospital, in evaluating the evidence about several issues in this inquiry, I have to consider the character, conduct and credibility of Sonny Lodge. I have set out my consideration of this in full in Chapter 18 in relation to Sonny Lodge's claims that he was victimised by prison officers.

10.48 However, I repeat here paragraph 4.41 about whether Sonny Lodge had a propensity for violence. The relevant evidence known to the inquiry is that:

- He had one conviction for causing actual bodily harm in 1987, at the age of 17, incurring a fine of £100.
- His sister said he was not aggressive and she had never known him to pick a fight.
- The day centre manager said Sonny Lodge thought he was one of the big boys but he never was.
- In evidence to the Prison Service Investigation and the inquest Father McCann said that Sonny Lodge told him he was not violent and did not commit violent crimes.
- In May 1998 Sonny Lodge was banned from Manchester Drug Service for six months for threatening behaviour towards one of the doctors.

- The diagnosis of dissocial personality disorder by the psychiatrist at Warrington Hospital was only tentative but, from the records, Dr Wright found it appropriate and said that risk of violence and threatening and abusive behaviour could be characteristic of the disorder.

Chapter 11: FRIDAY 28 AUGUST: THE DAY OF SONNY LODGE'S DEATH

Summary

11.1 Sonny Lodge was held in the segregation unit overnight. A chaplain visited him and passed on Sonny's concerns to a colleague. The medical officer assessed him as fit for adjudication and cellular confinement. Sonny was found guilty of attempting to assault Officer Bowcock and returned to the cell in the segregation unit for cellular confinement. Another chaplain spoke with Sonny's girlfriend and visited him twice. That evening Sonny killed himself.

Father McCann's evidence

11.2 On Friday morning, Father McCann met Mr Lodge when doing the chaplaincy's daily round of the segregation unit. This was before the adjudication. Father McCann had no prior knowledge of Mr Lodge, who seemed slightly distressed and wanted to talk. Father McCann was not aware of Ms A's telephone calls or his colleagues' visits to Mr Lodge.

11.3 Father McCann told the Prison Service investigators and the inquest that Mr Lodge said he had expected a *"nicking"* (disciplinary charge) that day because he was due for release and might get bail and he thought someone would try to prevent him being released. Father McCann said Sonny Lodge told him he expected something to be planted in the cell during the search and afterwards a confrontation occurred, triggered by his nervous laugh when he was upset by the state of his property in the cell after the search. He said that an officer had hit him in reprisal for an alleged assault on a Risley officer.

11.4 Father McCann said that when he left the unit he told the officer in charge, SO Knight, that the only person he was concerned about was Mr Lodge who seemed *"low and fed-up"*. Father McCann said he was not unduly concerned. He did not think that Mr Lodge was going to harm himself but only that he was in a *"down state of mind".*

11.5 In his statement to the inquest, Father McCann said he spent 10 or 15 minutes with Mr Lodge, who did not express any intention of suicide. As a chaplain he could raise an F2052SH. He said the chaplains were aware of the danger of suicide and always kept it in mind. In his evidence, Father McCann said he was uncertain whether he had known when he spoke to Mr Lodge that he had in the past been on suicide watch or whether he knew this only after Mr Lodge's death.

11.6 Back in the chaplains' office, Father McCann told his colleague, Mr Johnson, of his conversation with Mr Lodge. Father McCann said Mr Johnson knew some background and said he would speak to the adjudicating governor and also telephone Ms A as Mr Lodge has requested. Father McCann had no further involvement.

Mr Johnson

11.7 Mr Johnson was the Church of England chaplain and coordinated the chaplaincy service at the prison. He told the inquiry that he had not been directly involved in the exchanges between Ms Lorimer and Mr Palmer on Wednesday 26th. He had happened to be in their office, not his own, and he remembered Mr Palmer coming back on Thursday and saying Mr Lodge was surly but fine. Mr Johnson's involvement really began on Friday when Father McCann passed the case to him as duty chaplain as Mr McCann had an appointment outside the prison. Mr Johnson said that from the statements he made at the time he believed that he had connected Mr Lodge with the prisoner his colleagues had seen in the days before. Father McCann had not mentioned anything about Mr Lodge being at risk of suicide or self-harm. The concerns were about Mr Lodge's claim to have been assaulted by an officer. Mr Johnson spoke to the deputy governor about this. Later he went to the segregation unit to see Mr Lodge after the adjudication.

The adjudication

11.8 As a result of the incident in the cell Sonny Lodge was charged under Prison Rule 47 paragraph 22 with attempted assault on Officer Bowcock.

Medical examination before the hearing

11.9 Before the adjudication, Mr Lodge was seen by the prison doctor, Dr Rozycki, who was required to assess whether he was fit for adjudication and fit for cellular confinement, in case the adjudicator wanted to impose cellular confinement as a punishment. Dr Rozycki told the Prison Service investigation that he did not know Sonny Lodge nor see his medical or prison record and that he assessed his fitness on the basis of an examination of Mr Lodge's mood at the time, not his history. He thought it unlikely that knowledge of previous self-harm would have led him to make a different judgment on the day.

11.10 Dr Rozycki has recently made a statement at the inquiry's request. He told the inquiry that, at the time in question, there was no Prison Service policy requirement to

consider the Inmate Medical Record (IMR)as part of the assessment of fitness. Nor was it routine for him or other medical practitioners to ask for the IMR for the purpose of the assessment. The purpose was to assess fitness for adjudication or segregation on the particular day. It was not intended to be a full psychiatric examination with consideration of history. Dr Rozycki said he made a clinical assessment based on a face-to-face examination. He recalled that on occasions when he had any concerns he would call for the records and might also admit a prisoner to the hospital wing for full assessment. He said there was nothing about Mr Lodge's presentation that caused him to call for the IMR that day or to take any other action.

11.11 The clinical adviser to the inquiry has commented on the system of medical assessment of prisoners' fitness (see Chapter 13).

The evidence heard at the adjudication

11.12 Officer Bowcock's report of the alleged offence (Form F254) said:

"At approx 1945 on 27.9.98 on G wing in cell G3-24 I had just completed a cell search on BE8011 Lodge. He was returned to his cell whereupon I began to explain the rules and regulations pertaining to him during his stay on G wing. At this point, BE8011 Lodge became agitated and lunged at me attempting to assault me. I was in company with Officer Downs and after a short struggle we managed to restrain him and raised the alarm. Other staff arrived shortly and I was relieved of my position."

11.13 In a written statement, Officer Downs said that he witnessed Mr Lodge lunge at Officer Bowcock.

11.14 Governor McColm was the adjudicator. As is customary, the governor made a record of the hearing in manuscript notes on the F256. The account of the hearing and evidence given below is taken from that note.

11.15 The adjudication opened at 10.17 am. Sonny Lodge pleaded not guilty to the charge of attempted assault. Officer Bowcock read his report.

Questions to Sonny Lodge

11.16 Governor McColm asked Sonny Lodge if he had any questions. Sonny Lodge said that he came off a visit and was pulled in front of the SO and accused of swearing at an officer. He was taken to his cell and was there for just under an hour. He went to get his tea and came back upstairs. An hour later Mr Downs and Mr Bowcock told him to

take his clothes off for a search and took him to the television room while they searched the cell. Later he came back and went into his pad. The two officers were there. He said his property was everywhere and he was very upset but laughed. Mr Bowcock lunged at him. He tried to roll into a ball, lost consciousness then came round. He said he did not raise his hand to any of the officers.

11.17 The governor asked for SO Nuttall, Officer Downs and Officer Shaw to be called. A written statement from Officer Shaw says that Sonny Lodge told her he expected the officers to plant something in his cell. Officer Shaw did not attend the adjudication and her statement is not referred to in the record.

Questions to Officer Bowcock

11.18 The governor questioned Officer Bowcock, who said the search was his first contact with Sonny Lodge, and that he had decided on the search. Officer Bowcock said that was usual because he was a former member of the Dedicated Search Team (DST). The governor asked on what basis Sonny Lodge was searched. Officer Bowcock replied that there were comments in the observation book. He said they were looking for contraband and Lodge had had a visit that day.

11.19 Officer Bowcock denied that he had lunged at Sonny Lodge. The governor asked him to explain Sonny Lodge's movement towards him. Officer Bowcock said Sonny moved towards him. The governor asked if this was in a threatening manner, whether Sonny raised his arms and whether Officer Bowcock thought Sonny was going to assault him. Officer Bowcock replied yes to each question. The governor asked how he was restrained. The record says Officer Bowcock said he grabbed Sonny's upper torso but, in evidence to the inquest, Officer Bowcock said that the adjudicating governor misinterpreted what he said and in fact he had grabbed Sonny's right arm.

11.20 The governor asked Sonny Lodge where he got the bump on his head. He replied that it was during the incident. The governor asked Officer Bowcock whether Sonny Lodge had passed out. Officer Bowcock thought not but had left the cell.

Questions to SO Nuttall

11.21 SO Nuttall attended. He confirmed that the officers were detailed to search the cell. He said that he had become aware of the incident when the alarm bell sounded. When he went to the cell, Mr Lodge was being restrained by two officers. He was lapsing into unconsciousness or feigning unconsciousness. A hospital officer was present.

Questions to Officer Downs

11.22 Officer Downs attended. He said that the decision was made to search Sonny Lodge from entries in his record. He said Sonny was agitated when he came back to the cell. He walked into the cell and shook his head. Officer Bowcock pointed out his attitude and referred him to the rules. Officer Downs was standing at the door ready to go. At this point Sonny made a grab for Officer Bowcock. The governor asked whether Sonny raised his hand. Officer Downs replied, *"They were towards the officer."* The governor asked whether Sonny Lodge moved towards Officer Bowcock. Officer Downs confirmed that he did. The governor asked whether Officer Downs interpreted the move as threatening. Officer Downs said that he asked Officer Cowley to press the alarm bell and went to Officer Bowcock's assistance. Officer Bowcock had stepped to one side and Officer Downs thought he had got hold of an arm. Officer Downs went over to where they were and Sonny Lodge's arm was tucked underneath. There was a bit of a struggle. He said he was not aware of Sonny Lodge being unconscious at any stage but was told about it afterwards.

Further questions to Sonny Lodge

11.23 The governor asked Sonny whether there was anything else he wanted to say. He said*, "No, Sir."* The governor asked if he moved towards the staff. He replied, *"Not at all."* The governor asked again whether there was anything else Mr Lodge wanted to say. Sonny Lodge replied that he just laughed and there was nothing else.

Governor's verdict

11.24 The governor found the charge proved. The record says that Mr Lodge made no plea in mitigation. The governor considered a conduct report which gave details of the previous adjudication on 24 July 1998 for endangering health and safety and said that Mr Lodge was unemployed and his record contained various adverse comments about behaviour and attitude/swinging lines/being in other cells/sacked from the workshop. It did not refer to the entry in the history sheets about his having been on F2052SH. The report gave his release date as 28 August, the day of the adjudication, but there was a rough note on it indicating remand from Huyton magistrates' court. The record of hearing says that Sonny did not wish to comment on the report. The governor gave a penalty of prospective forfeiture of 14 days remission, which would become effective only if he was convicted on the criminal charge, and four days' cellular confinement.

Subsequent statements to the Prison Service investigators and the Coroner's officer

Governor McColm

11.25 Governor McColm told the Prison Service investigators that just before the adjudication Governor Munns told him of a telephone call, probably from the chaplain, about Mr Lodge and gave him a piece of paper that mentioned a problem with an officer at Risley and that there might have been a stitch-up on G wing. He was not, however, aware that Sonny Lodge had any history of self-harm. He had considered adjourning the adjudication when Sonny alleged that the officer lunged at him but he understood Sonny might be discharged that day and he believed he could deal with the issue satisfactorily so he decided to proceed.

11.26 Governor McColm said he had not investigated the occurrences that Officer Bowcock said had justified the search and had not looked at the observation book. He did not see control and restraint forms or a healthcare report of injury for the bump on Sonny's head. During the adjudication, Sonny had been emotional, cross and at one point tearful. At the end he seemed resigned. Part of Governor McColm's reasoning for imposing four days' cellular confinement was to keep Sonny off the wing until after the bank holiday weekend in view of the information from Governor Munns. He said he would be more comfortable with his safety and how he would be treated in the segregation unit than on the wing. He felt uneasy about him going back to the wing.

11.27 After the adjudication he had seen SO Knight and asked him to keep an eye on Sonny but that was to do with staff approaching him, not that he had picked up any sign he might self-harm. He wanted to make sure he was safe. If there was a history, then at least the segregation unit staff knew about it. He did not say this specifically to SO Knight but knew him to be an experienced SO who would probably have shared some of the governor's concerns.

11.28 Governor McColm said that others had described Sonny Lodge as wilful but he did not strike him that way. Governor McColm said he had had to make a decision about where to place Sonny. After Sonny's death, Governor McColm felt painfully aware that it was his decision had led to Sonny being in segregation.

11.29 In evidence to the inquest, Governor McColm said that the Deputy Governor of Manchester prison, Mr Munns, had told him before the hearing that Sonny said he had

been *"fitted up"* by officers on G wing as payback for an incident when he was at Risley. Governor McColm said that he adjourned the hearing to call other witnesses, SO Nuttall, and Officers Downs and Shaw. The hearing recommenced after about an hour and a half. The hearing itself lasted about 20 minutes. He said that the weight of evidence was such that he had no alternative but to find Mr Lodge guilty.

Officer Gartside

11.30 Officer Mike Gartside was one of the three segregation officers and an escorting officer at the adjudication. He told the Prison Service investigators that at the adjudication Mr Lodge got very upset as the evidence was being heard. He was protesting his innocence and was emphatic that he *"just didn't do it".* At one time he started crying. SO Knight passed him a Kleenex and the governor gave him time to compose himself. At the end of the adjudication he was quiet and resigned. Officer Gartside went off duty at lunchtime

11.31 Officer Gartside said he had no reason to believe Mr Lodge had a history of self-harm or was likely to self-harm. He had not written the conduct report for the adjudication and did not know whether Mr Lodge's records were available in the segregation unit. He commented that the F2052SH booklet is conspicuous in a prisoner's file because of its distinctive colour.

SO Knight

11.32 SO Ronald Knight told the Prison Service investigation that Sonny Lodge did not give him any impression at all that he was a person liable to self-harm; he was not aware of a past history of self-harming and he did not know that Sonny Lodge had been on an F2052SH. According to the Treasury Solicitor's summary note of the inquest, SO Knight said he was aware that Mr Lodge had been subject to an F2052SH but this did not give him cause for concern, rather he just needed to be kept an eye on.

11.33 SO Knight told the inquest that Sonny Lodge appeared quite cheerful at breakfast, that during the adjudication he appeared quite emotional and at one point he might have offered him a tissue. He did not recall Governor McColm or anyone else coming to him with any information about Sonny after the adjudication.

11.34 He recalled that during the adjudication Sonny had said something about his past catching up with him. SO Knight thought this was in connection with the fact that Officer Bowcock was a Liverpool officer.

Evidence to the inquiry

SO Knight

11.35 SO Knight told the inquiry that he believed that Sonny's core record which would have contained the old F2052SH was not available in the segregation unit as it had been sent to reception because of his impending release or change of status. He said that the note of his evidence to the inquest was incorrect and it was two days after Sonny Lodge's death when he found out that he had formerly been on an F2052SH.

Governor McColm

11.36 Governor McColm told the inquiry that from his brief conversation with the Deputy Governor he understood that Sonny was likely to be released on bail later that day. He did not know any detail of the incident at Risley that was mentioned as the possible cause of a grudge. He said he had considered whether he could investigate Sonny's counter-allegation properly. He wanted to understand the cell search and to check it was legitimate. He had adjourned to obtain evidence from the senior officer who would have had to authorise it. SO Nuttall had confirmed that the staff were detailed to search and that he knew they were searching. It was correct for staff to search if they had concerns about someone. He had not attached any significance to Officer Downs saying that there were entries in Sonny Lodge's record whilst Officer Bowcock said there was an entry in the observation book. He took it there was an entry somewhere giving cause for concern. He had not asked for use of force forms which at that time tended to be written in formulaic terms and were unlikely to be helpful.

11.37 Governor McColm said he had been satisfied that the charge was proved. The officers were clear and consistent in their evidence whereas Sonny Lodge was vague. He had considered whether to adjourn for further investigation but having heard from the three people in the cell at the time of the incident he did not think that there was likely to be significant other evidence.

11.38 Governor McColm has commented that the notes on the F256 are not a verbatim record. They do not capture everything that was said and are not required to do so. Nor can they capture body language or emotions. Even so, the record ran to eight continuation sheets. Governor McColm says that, at the time, it was usual for an adjudication to be completed without continuation sheets and to be over in a matter of minutes. In this case, the adjudication took some 20 or 25 minutes.

11.39 Governor McColm told the inquiry he had been uneasy about seeming animosity between Sonny Lodge and Officer Bowcock in the adjudication room. When deciding on the punishment he had taken into account that Sonny might be released that afternoon but otherwise he wanted to keep him off the wings for the four days of the bank holiday weekend to avoid any possible conflicts between him and the staff. He was clear that he had not wanted to impose any added days. In the segregation unit, movements were controlled and there were daily visits from the doctor and chaplain. He said Mr Lodge's welfare was at the forefront of this mind. Asked whether he had allowed his unease to affect his decision on the charge, Mr McColm said that now, ten years later, he could not honestly say what the sequence of his thinking had been. He had not been aware that Sonny had self-harmed or been on F2052SH. The concern he felt was about the hostility between Mr Lodge and the officer. Sonny Lodge seemed upset with the officer and the evidence but it was not unusual for someone who felt they had been *"stitched-up"* to be upset or emotional in an adjudication. Nothing had prompted him to think that Sonny was at risk of suicide. He had asked SO Knight to keep an eye on Sonny. He wanted SO Knight to make sure Sonny was OK and had calmed down after the adjudication but that was not because of any thought that he might self-harm.

After the adjudication

11.40 Mr Johnson went to the segregation unit to see Sonny. On the way, he saw Governor McColm who told Mr Johnson that he had found the charge against Mr Lodge proved and that as part of the penalty he had imposed four days' cellular confinement motivated by a desire to keep him out of harm's way where he could have no further contact with the G wing officers. Governor McColm asked Mr Johnson to explain to Mr Lodge that he did not want him to go back to the wing and was trying to help him.

11.41 In his interview for the Prison Service investigation, Mr Johnson said he saw Mr Lodge at about 11.15 am. Mr Johnson explained to him what the governor had done and why. Mr Johnson said Mr Lodge was quite happy and understood. Mr Lodge's only concern was that he would spend the bank holiday weekend in segregation. He asked for some books and a Bible, and for Mr Johnson to find out the result of his bail application. This was the first time Mr Johnson had met Mr Lodge.

11.42 Later, Mr Johnson spoke with Mr Lodge's girlfriend (Ms A) on the telephone. She was upset because the bail application had been refused. Mr Johnson said she had been building up hopes for Mr Lodge getting home and was worried about what was

going to happen to him. She was also having difficulty arranging an early visit, as prison records had not yet been changed to show Mr Lodge was on remand not convicted. Mr Johnson left a message asking Mr Lodge's solicitor to tell him why bail had not been granted and he sorted out the problem about visiting.

11.43 Sometime between 3 pm and 4 pm, Mr Johnson went to see Mr Lodge again, taking the books he had asked for. He talked about when Ms A would visit, and was able to reassure him he would not be moved to Liverpool. Mr Lodge asked if he could go to mass on Sunday and Mr Johnson explained how to arrange this. He said he would come back to tell Mr Lodge the reason for the bail refusal that day, if the solicitor telephoned in time, and otherwise the next day. He left just before 4 pm to be back in his office for the solicitor's call.

11.44 Before leaving the segregation unit, Mr Johnson went into the office and discussed with the staff what he had done. He recalled that someone asked if Mr Lodge was suicidal and Mr Johnson said he did not think so. He had been reassured that he would not go to Liverpool prison and would be safe in the immediate future. Staff had been fully briefed by Mr McColm and were going to keep an eye on him. They all agreed Sonny Lodge was not suicidal.

11.45 Mr Johnson said he could not see any signs Mr Lodge might have been thinking of committing suicide. He did not know him. Though he seemed flat and pretty unresponsive, his response was positive that the immediate problem about Liverpool was solved and he was not going to be beaten up.

11.46 Mr Johnson said he was aware that the Risley incident occurred at a hospital after an incident of self-harm but he did not know the details. He did not know the full extent of the history or that there had been a really determined and skilful attempt at self-harm and lots of others in the past. Nor that Sonny Lodge had written clearly about suicide by hanging. He understood later that Ms A mistakenly believed that the prison was reading Mr Lodge's letters. Mr Johnson commented that if they had known the content of the letters, Mr Lodge would have been placed on almost permanent watch.

11.47 Mr Johnson said to the Prison Service Investigation that in his opinion Sonny adopted a veneer that:

"…would have taken someone far more skilful than I and…staff in the segregation unit to pierce. The point is that I had only met him twice; the staff in the seg unit had only met him that day. I don't think staff on G wing knew him all that well, he kept his head down."

11.48 At the inquest, Mr Johnson said he was familiar with the F2052SH procedure. Given his knowledge of Mr Lodge's history, he was concerned that he was in a single cell but from all his knowledge he was safe to be left there.

11.49 Mr Johnson told the inquiry that he believed that it was only after Mr Lodge's death that he knew that Ms A had told Ms Lorimer she was concerned Mr Lodge might harm himself. His understanding was that Ms A was worried about Mr Lodge because he had been in difficulties with prison officers and was worried he might be moved to Liverpool which had a reputation among prisoners at the time as an intimidating prison and where he was afraid he might be bullied because of the Risley incident.

11.50 Mr Johnson said that warning signs of suicidal intent might be when someone seemed detached, flat, not looking forward, unwilling to engage. By contrast, Mr Lodge was talking rationally about what would happen in the coming days. He took the initiative to ask about mass on Sunday and he asked for books. He was looking forward to his girlfriend's visit and what was going to happen in future. He still had some life and spark about him. In addition, Mr Johnson had confidence in the unit staff.

Sonny Lodge's death

11.51 An officer recalled later that Sonny had been sitting normally in his cell when he did the roll check at about 4.40 pm. The evening meal was usually served from about 6 pm. Prisoners in the segregation unit were unlocked one at a time to collect their meal. On 28 August the meal was delayed by 15 to 20 minutes because of the death of a prisoner on A wing. At about 6.20 pm an officer opened Sonny's cell to find him slumped against the pipes under the window with a ligature made of bed sheets around the widow bars and his neck. The officer called for assistance. The senior officer brought scissors from the office on the floor below and cut the ligature while two officers supported Sonny's weight.

11.52 A health care officer and a nurse responded to the emergency call and attended the cell with equipment. They attempted cardio-pulmonary resuscitation and requested the doctor and a 999 ambulance. The prison medical officer came from the reception area at 1842. He pronounced Sonny Lodge dead at 1845.

11.53 In his final letter to his girlfriend, Mr Lodge expressed his despair.

"My head is right but my heart has been ripped open and there is a lot of burning but the pain will only last for as long as this goes on. You don't know how much I wanted you to be there on Friday but once again everything has gone so dark and I can't breathe. The boogy man is near, just got to go on through. Can't believe the amount of bullshit that fuckin twat has come out with, I think they will try even harder now the screws to proper bullock me up. And believe me…they are coming from all angles! Just want to sleep now. Never want to wake up. Can't believe this. WHY! Only hope you still want me in your life…So they are twisting the knife in more now! I can take the pain from these cunts but can't take on yours my love because if you are upset or worried then I am slowly but surely losing it and if I do my love, believe me, I will go out with the biggest bang ever…"

PART THREE

THE ISSUES THE INQUIRY EXAMINED: CONSIDERATION, FINDINGS AND RECOMMENDATIONS

This part of the report contains the inquiry's consideration of the evidence, the findings and some recommendations.

It contains some evidence that has not been set out in the narrative in earlier chapters. This includes some of the advice the inquiry received from Dr Wright, information about Prison Service policies and procedures and changes at Manchester Prison, reference to research findings, and some observations that witnesses made in evidence to the inquiry.

Findings are based on the balance of probabilities but, in weighing the evidence, I have also had regard to the principle that the more serious the allegation is, the more cogent must be the evidence to prove it.

I have made some recommendations but have exercised restraint in doing so. Those who work in prisons are often best placed to draw lessons from past events and to devise operational solutions to deficiencies. I hope that the Prison Service and those who are responsible for healthcare in prisons will consider the findings and decide for themselves whether there are further lessons to be drawn.

Chapter 12:

ISSUES RAISED IN THE CLINICAL REVIEW (1): CLINICAL CARE; IDENTIFYING RISK OF SUICIDE; THE EFFECT OF A SENSE OF VICTIMISATION,

Introduction

12.1 The inquiry undertook to examine whether the medical care of Sonny Lodge was appropriate, including the assessment that Sonny Lodge was fit for adjudication and cellular confinement on 28 August 1998.

12.2 Dr Nat Wright prepared a clinical review of Sonny Lodge's medical care in prison, based on the documentary evidence and written statements obtained by the inquiry. He also gave oral evidence at the public hearing, and provided a written summary from Sonny Lodge's GP records prior to his admission to prison.

12.3 I asked Dr Wright:

- to examine whether the healthcare provided to Sonny Lodge was appropriate, applying the principle of equivalence with treatment provided by the NHS.

In addition to his review of the clinical care of Sonny Lodge, I asked Dr Wright to advise me about:

- any factors that might have contributed to Mr Lodge's state of mind at the time of his death; and
- any lessons that might help to prevent future such tragedies.

12.4 I have referred to Dr Wright's advice where relevant in other parts of the report but it is set out in this chapter and the next one in more extended form. This chapter deals with clinical care, the significance of a sense of victimisation, and issues in identifying risk of suicide. The next chapter deals with the particular issue of assessing prisoners' fitness for adjudication and cellular confinement.

Summary of Dr Wright's advice

12.5 In respect of Sonny Lodge's clinical care, Dr Wright advised that, with a few minor exceptions, he was impressed by both the standard of note keeping in the clinical record and clear references to how healthcare provision for Sonny Lodge would be planned. There also appeared to be timely reviews of the healthcare he was receiving. However, he argues that there was a systems failure in the process of assessment for

fitness for adjudication and cellular confinement. He commented on the need for care and assessment to be based on consistent therapeutic relationships. This is considered further in Chapter 13.

12.6 Dr Wright commented on the identification of risk and the difficulty of predicting suicidal intent from one-off interactions. He considered that opportunities to prevent Mr Lodge's suicide were missed in the final days of his life, in particular in response to the telephone calls from his girlfriend. He commented on the high concentration of vulnerability and diagnosis of personality disorder in prisons and on changing clinical approaches to personality disorder.

12.7 Dr Wright considered that, while Sonny Lodge was in Manchester prison, he developed increasing feelings of powerlessness and hopelessness, including a sense that he was being victimised by prison staff. Dr Wright advised that feelings of victimisation may be harmful to mental health and may have contributed to Sonny Lodge's decision to end his life.

12.8 Dr Wright saw no evidence that Mr Lodge's feelings of victimisation were the consequence of any psychotic illness. He considered that they stemmed from real events but attached two caveats: once a person feels a sense of victimisation and injustice they may become extra sensitive, seeing victimisation where another person would not; and a prisoner might interpret as victimisation a legitimate exercise of authority by staff.

Clinical care

Coming off drugs

12.9 When Sonny Lodge was admitted to Risley prison on 15 June, a reception health screen recorded that he reported a daily heroin habit of 14 years' standing and that he had injected about one gram 72 hours earlier. He also reported smoking about 30 cigarettes a day. He was placed on a detoxification regime comprising dihydrocodeine for seven days and zopiclone for five days.

12.10 Dr Wright advises that the practice of prescribing dihydrocodeine conformed to common, reasonable and acceptable practice at the time. UK National Guidelines for the treatment of drug misuse produced in 1999 endorsed dihydrocodeine as having a place in the treatment of heroin users. That changed in 2007 when the National Institute for Clinical Excellence (NICE) Guidance for Opioid Detoxification stated that dihydrocodeine

should not routinely be used. But in 1998, dihydrocodeine was considered less toxic in overdose than methadone and, following a number of deaths from methadone in the prison setting, it was considered the drug of choice in secure environments.

12.11 Dr Wright advised that recent evidence now documents the superior efficacy of buprenorphone (subutex) compared to dihydrocodeine for detoxification from opiates but in 1998 it was not available for the treatment of drug dependence. Buprenorphone in the form of temgesic had been prescribed in community settings but was associated with significant potential for abuse and it was not considered suitable for prison settings where, relative to the community, there was raised potential for diversion. These factors led to dihydrocodeine being the drug of choice in secure environments.

12.12 Dr Wright advised that in 1998 zopiclone was routinely prescribed to ameliorate symptoms of insomnia that are a feature of withdrawal from opiates. In 1998 it was considered to be less habit-forming than traditional benzodiazepines (such as temazepam, lorazepam or diazepam). Current NICE guidance is that zopiclone is no more cost-effective than other benzodiazepines.

The instances of possible fits

12.13 The records refer to observed or reported instances of Sonny Lodge experiencing a seizure or fit twice on 17 June, then on 19 June and on 27 August. The psychiatrist who interviewed Mr Lodge at Warrington Hospital recommended, but did not prescribe, an anti-convulsant medication, tegretol, which decreases nerve impulses and is used in the treatment of seizure disorders, among other conditions. The medical officer at Garth prison decided not to prescribe this medication.

12.14 From the medical history, Dr Wright advised that the diagnosis and management of the seeming fits Sonny Lodge experienced in prison were appropriate. There was no history or diagnosis indicating epilepsy and on each occasion Mr Lodge was said to have recovered quickly. Dr Wright considered it unlikely that the episodes were true epileptic seizures. From his experience, he thought it more likely they were feigned for some form of secondary gain. Further, he inferred that the psychiatrist might have recommended tegretol, not because of reported instances of seizures, but because of his diagnosis of dissocial personality disorder for which the drug was often prescribed, although there was no consensus about the value of doing so and no strong evidence

base for any beneficial effect. He noted that the decision not to prescribe tegretol was made by the doctor at Garth after a comprehensive initial examination.

Medication for dental pain

12.15 During August, Sonny Lodge reported dental pain. Dr Wright considered the care plan appropriate in that it started with a non-steroidal anti-inflammatory medication with progression to a stronger analgesic at a subsequent appointment and a dental appointment was arranged. Penicillin V antibiotic medication was also prescribed. Dr Wright advises that this practice is now discouraged as the medication has limited effectiveness but such a prescription given in 1998 would not have been outside reasonable and acceptable primary care practice.

Medication records

12.16 Dr Wright noted, however, that entries relating to the co-codamol in the Prescription and Administration Record Chart were confusing in places. Between 23 August and 27 August the only two entries are DNA (did not attend) made on the evening of 24 August and the morning of 25 August. (Mr Lodge was in Liverpool those days attending Huyton police station and subsequently the magistrates' court.) Dr Wright advised that it might be that positive entries of administering the drug have not been recorded but that is not in accordance with best practice.

Sonny Lodge's mental health

12.17 The psychiatrist at Warrington hospital on 27June summarised his impression of Sonny Lodge's condition as: dissocial personality disorder; adjustment disorder or possibly mild depression; and that he had no suicidal plans. He recommended but did not prescribe cipramil, an antidepressant, as well as the anticonvulsant, tegretol. Having had access to more extensive records than were available to the hospital psychiatrist, Dr Wright advised that the diagnosis seemed to be in keeping with the behaviours displayed by Mr Lodge and there was nothing in the bundle of papers to suggest an underlying depressive illness.

The meaning of 'personality disorder'

12.18 Dr Wright elaborated on the meaning of the diagnosis of dissocial personality disorder. He said the term more usually used now was antisocial personality disorder. The characteristic traits for the classification were: *"lability* [instability] *of mood;*

impulsivity; difficulty forming relationships; in close relationships, fluctuating intensity of emotional involvement; exaggeration; risk of violence; threatening, abusive behaviour".

12.19 As regards medication, Dr Wright advised that it was unlikely either at that time, or currently, that there would be consensus regarding the prescription of antidepressants and anticonvulsants, in this situation. Dr Wright commented that the healthcare plan devised on 28 June at Garth prison was appropriate and encouraged fostering a strong therapeutic alliance and encouraging involvement of Mr Lodge in daily living activities. He considered such interventions more important than medication in conditions of personality disorder and adjustment reaction. Dr Wright concluded that, in the absence of a clinical consensus in the mental health field about the use of prescribed medication for personality disorder, the decision by the prison doctor at Garth to withhold anti-epileptic and antidepressant medication was within common and acceptable practice. He was impressed by the quality of the doctor's examination recorded when Mr Lodge was admitted to Garth and noted, also, that when he was admitted to Manchester the medical officer appeared to have conducted a clear and purposeful interaction with Mr Lodge to try to gauge how much he was at risk.

Psychiatric follow-up

12.20 The inquiry noted that the psychiatrist at Warrington Hospital had recommended psychiatric re-assessment and the doctor at Garth recommended counselling. The inquiry asked Dr Wright whether he was satisfied that there was appropriate continuity of care for Mr Lodge's mental health.

12.21 Dr Wright said that, until about three years ago, personality disorder was a *"diagnosis of exclusion",* that is a condition whose presence cannot be established with complete confidence from examination or testing but is derived from elimination of other reasonable possibilities. The term was used to explain antisocial behaviour that could not be explained by a diagnosable form of thought disorder that could be treated and it therefore meant that patients so labelled received no mental health service.

12.22 Thinking changed in 2003/2004 with a landmark document published by the Department of Health (DH)[1]. Current practice identifies therapeutic approaches and

[1] Department of Health: *Personality disorder: no longer a diagnosis of exclusion - policy implementation guidance for the development of services for people with personality disorder* (January 2003)

makes clear that people with a personality disorder should not be excluded from any health or social care.

12.23 Dr Wright commented, however, that at the last survey of prison populations some 72 per cent of prisoners were said to have an antisocial personality disorder. Conventional wisdom in 1998 was that little could be done to treat this condition that was so common throughout the prisons and Sonny Lodge was assessed by the psychiatrist at outside hospital as having a low risk of suicide. That made him low priority for psychiatric follow-up.

Identifying risk of suicide or self-harm

12.24 Dr Wright drew a distinction between the F2052SH system, which he saw as primarily a screening tool, and its successor, the ACCT plan, which adopts a care planning approach. Dr Wright said that the F2052SH tended to be reduced to a screening tool for something that was not really screenable. (Chapter 14 describes the main features of the F2052SH system and the ACCT procedures that have now replaced it. ACCT means Assessment, Care in Custody and Teamwork.)

12.25 Dr Wright was asked whether a doctor assessing fitness for adjudication should be made aware of a closed F2052SH or ACCT plan. (This is considered further in Chapter 13.) Dr Wright said that they should, in that some information was better than no information, but the problem was that F2052SH, personality disorder, and mental illness were so common in prison. Suicide was notoriously difficult to predict, in particular from one-off interactions, and what a person said should not necessarily be taken at face value.

12.26 Nonetheless, Dr Wright considered that opportunities were missed in the final week of Sonny Lodge's life to open an F2052SH and to plan care accordingly. In particular, he considered the warnings from Mr Lodge's girlfriend to be a *"red warning sign".* At the same time, certain activities by discipline staff heightened Sonny Lodge's sense of hopelessness.

Sonny Lodge's sense of victimisation

12.27 Dr Wright was aware from the terms of reference of the investigation and from seeing some of Mr Lodge's letters that he believed he was being victimised by discipline staff. Dr Wright considered whether this was a deluded belief caused by an underlying mental illness with symptoms of paranoia. Dr Wright found no evidence in the papers of

any underlying paranoid illness as cause for Mr Lodge's feelings of victimisation. He concluded that the history of events during Mr Lodge's time in prison indicated various real occurrences that contributed to his sense of being victimised. He concluded from the records that there was not a wide gap between Mr Lodge's experience of reality and his perception of it. Dr Wright also commented that frequent cell moves might have worsened Mr Lodge's mental instability at a time when stability was required.

12.28 Dr Wright advised that a sense of victimisation in the environment of the prison could have left Mr Lodge feeling increasingly powerless and hopeless, as reflected in his letters, and ultimately such feelings could contribute to a state of mental ill-health and a desire to end his life.

12.29 He concluded, in addition, that there were occasions when Mr Lodge disclosed his low mood and feelings of suicide with a third party and that there was a *"failure on the part of all stakeholders in not re-opening an F2052SH in the days immediately preceding his death"*. Dr Wright concluded that Sonny Lodge's death could have been prevented.

12.30 In oral evidence, Dr Wright elaborated on the relationship between a sense of victimisation and low mood. Dr Wright referred to the parameters of ill- health identified in the 1986 Ottawa Charter of the World Health Organisation. One set of triggers for ill-health is classified as *"political/legal".* Dr Wright said that in a clinical review it was legitimate to ask whether there were factors outside the patient's control, attributable to people in authority exercising power, that trigger ill-health.

12.31 Dr Wright was asked whether Sonny Lodge might perceive that he was being victimised without that being either a consequence of mental illness or objectively justified. In other words, that the officers might be using their authority appropriately but their actions interpreted by Sonny Lodge as victimising. Dr Wright confirmed that this was possible and commented that: *"Once somebody feels victimised there is an amplification of their emotions such that any small trigger is then amplified."*

12.32 Dr Wright noted that Governor McColm and Officer Gartside said that at the end of the adjudication Sonny Lodge presented as *"resigned"*. Dr Wright took that to indicate a sense of powerlessness. He concluded that in the final week of Sonny Lodge's life there was *"political/legal"* exercise of power that was acting against his mental health. Referring to his sense of injustice about not being released, then being subject to a cell

search, then the rules being put on the wall, Dr Wright said it gave a sense of how somebody could feel that there was no way they would be able to fight. He commented that it might well be that some individuals were more sensitive to these kind of factors but, according to modern healthcare thinking, the way that that could be distinguished was through ongoing assessment and multi stakeholder involvement.

Findings

12.33 Drawing on Dr Wright's advice,

I find that:

- Clinical care for Sonny Lodge's physical health was appropriate and consistent with practice at the time.
- Clinical record-keeping was generally good except for an apparent practice of recording on medication charts only when patients did not receive medication and not when they did. That is not reliable or satisfactory.
- The Prison Service did not deliver the psychiatric reassessment, counselling and support to stay off drugs which doctors advised that Sonny Lodge needed.
- There is no evidence that Sonny Lodge's feelings of victimisation were the consequence of any psychotic illness.
- A sense of victimisation in the prison environment could have left Mr Lodge feeling increasingly powerless and hopeless, as reflected in his letters, and ultimately such feelings could have contributed to a state of mental ill-health and a desire to end his life.

Chapter 13:

ISSUES RAISED IN THE CLINICAL REVIEW (2): ASSESSING PRISONERS' FITNESS FOR ADJUDICATION AND CELLULAR CONFINEMENT

Introduction

13.1 In his clinical advice to the inquiry, Dr Wright argued that there was a systems failure in the process of assessment for fitness for adjudication and cellular confinement. He commented on the need for care and assessment to be based on consistent therapeutic relationships. This chapter sets out Dr Wright's advice and describes current Prison Service policies and the system operating now in the segregation unit at Manchester prison.

The medical officer's assessment of Sonny Lodge's fitness

13.2 Before the adjudication on 28 August, Mr Lodge was seen by the prison medical officer who was required to assess whether he was fit for adjudication and fit for cellular confinement, in case the adjudicator wanted to impose cellular confinement as a punishment. The medical officer told the Prison Service investigation that he did not know Sonny Lodge nor see his medical or prison record and that he assessed his fitness on the basis of an examination of his mood at the time, not his history.

Dr Wright's advice

13.3 Dr Wright advised that in 1998 a clinician faced with a request to certify fitness for adjudication and cellular confinement would in all probability do so unless the patient was an inpatient in a hospital wing. However he considered this unsatisfactory.

13.4 Dr Wright noted underlying problems with the system. Asking a doctor to make an assessment for a purpose other than a therapeutic one and which may have adverse consequences for the patient may create a conflict of interest and harm the therapeutic relationship between doctor and patient. Speaking generally, he felt that this conflict, coupled with the large number of such assessments, meant that they were often little more than paper exercises.

13.5 Dr Wright suggested that the ideal arrangement would be for prisoners' general practitioners to provide a report to an independent practitioner commissioned to undertake their own clinical assessment. He drew a parallel with eligibility assessments by the Department for Work and Pensions. Accepting, however, that this might not be

practicable, Dr Wright said that he understood that current thinking favoured a system that was a compromise between logistics and clinician independence, namely multi-disciplinary assessment with input from healthcare and discipline professionals.

13.6 In his oral evidence, Dr Wright enlarged on the role of healthcare in reviewing prisoners held in the segregation unit. He considered that going round a segregation unit spending a few moments at each door, without even a clinical area for further examination was a poor instrument for assessing mental health. Doctors were *"deferred to and defaulted to"* but felt vulnerable to unrealistic expectations where they were expected to take clinical responsibility in a setting that was not conducive to making satisfactory judgments. Dr Wright considered this a systemic failure.

Dr Wright's favoured model

13.7 The model Dr Wright preferred was for a dedicated registered mental health nurse to have the segregation unit as part of their responsibility and for that person to be actively care planning, building up therapeutic alliances with prisoners in the segregation unit and working in close collaboration with discipline staff. Dr Wright felt this model had been slow to be adopted, partly because of historic resistance in primary care to considering personality disorder as a treatable condition. Dr Wright stressed the importance of dedicated staff working in the segregation unit, not a rotation of a large number of staff primarily based elsewhere.

13.8 Dr Wright advised that new IT systems meant that it was now possible. in at least some prisons. for healthcare staff in the segregation unit to have access online to medical records. He did not think it was possible to make an accurate assessment of risk without access to records, but reference to records was not a sufficient condition, as the doctor was being asked to make a one-off screening judgment rather than engaging in ongoing assessment through a therapeutic alliance over a period of time.

13.9 In oral evidence to the inquiry, Dr Wright said:

"Modern clinical practice in both the drug misuse and mental health fields…is around a strong therapeutic alliance which is based…on an ongoing relationship with an individual in which unconditional positive regard is expressed, and also an environment in which they feel free to disclose their health and social need."

This was the best way to identify risk, to reduce it and treat it. .Dr Wright considered it was achievable in prison but required culture change.

Changes to assessing fitness

13.10 There have been changes to the system of assessing fitness for adjudication and segregation since 1998.

13.11 Prison Service Order (PSO) 2000 on Adjudications (in force from January 2006) states that *"a list of all those appearing before the adjudicator must be passed to the Healthcare Unit in sufficient time to enable any relevant concerns about individual prisoners to be given to the adjudicator before the start of the prisoner's adjudication."* (PSO 2000, paragraph 2.25)

13.12 The PSO also stated that the adjudicator *"may also wish to take into account"* information in any F2052SH or ACCT (PSO 2000, paragraph 2.25).

13.13 PSO 2000 was subsequently amended. The current guidance states:

"before any punishment of cellular confinement…is imposed…a medical practitioner or registered nurse must first complete an Initial Segregation Safety Screen and the adjudicator must take account of any medical advice that the punishment is not suitable when making his or her decision." (PSO 2000, paragraph 7.27A)

Among other questions, the Segregation Safety Screen asks*: "Has the person self-harmed in this period of custody/are they on an open ACCT OR is the person currently taking any anti-psychotic medicine?"*

13.14 Notes on the form say that the screen should be completed after:

- a discussion with the prisoner
- reference to the clinical record and any other relevant documentation
- gathering information from other members of the care team/discipline staff
- reviewing the nature of the incident which led to segregation being necessary to check for indicators of mental distress.

13.15 PSO 1700 gives instructions on the use of Segregation. PSO 2000 (on Adjudications) advises that a prisoner serving a punishment of cellular confinement is subject to the observational requirements applying when segregated under the provisions of PSO 1700. PSO 1700 says that the segregation screening form should be completed for any prisoner placed in segregation to await adjudication for longer than four hours.

13.16 Paragraph 4 of PSO 1700 states: *"The doctor must visit each prisoner in segregation as often as their individual health needs dictate and at least every three days. A registered nurse or healthcare officer must make the assessment on all other days, so that a member of healthcare staff visits the prisoner every day. Healthcare staff must assess the physical, emotional and mental well being of the prisoner and whether there are any apparent clinical reasons to advise against the continuation of segregation (including cellular confinement)."*

13.17 Dr Rozycki was the medical adviser at Manchester who assessed Sonny Lodge on 28 August. He has commented on these changes in arrangements for assessing fitness. As a specialist in psychiatry with many years' experience, he felt that the system in operation in 1998 may have had its flaws and has since been improved but that it was not ineffective. He told the inquiry that, in settings other than prisons, it was not unusual for medical or mental health assessments to be made without reference to history, which was not always available. Dr Rozycki said that, for his part, assessments were certainly not 'paper exercises'. He conducted clinical assessments and would call for records or admit a patient to healthcare if he had cause for concern.

Current practice at Manchester prison

13.18 In 1998, healthcare in prison was provided by the Prison Service. Healthcare in prisons is now commissioned by the local Primary Care Trust for each prison. The head of healthcare at Manchester prison, Ms Crowther, provided a written statement to the inquiry responding to Dr Wright's advice about risk assessment and healthcare for prisoners in segregation. She told the inquiry that present practice at Manchester reflects Dr Wright's model of good practice.

13.19 Mental Health In-Reach services at Manchester prison are provided by the Manchester Mental Health and Social Care Trust who have a service level agreement with the Primary Care Trust. There is a Mental Health In-Reach Team. It consists of a Consultant Psychiatrist and Associate Specialist in Psychiatry, a manager, a Clinical Lead Registered Mental Health Nurse (RN-MH), one Dual Diagnosis (substance abuse and mental health) Specialist Registered Mental Health Nurse, five Registered Mental Health Nurses, one Lead Group Worker Registered Mental Health Nurse and one Group Worker.

13.20 One of the mental health nurses is responsible for work within the segregation unit and is covered by another team member in her absence. Another nurse, who may be a general nurse, attends the segregation unit at the weekend.

13.21 Ms Crowther comments in her statement that Dr Wright advised that a therapeutic alliance between prisoner and health professionals should be adopted in the segregation unit. Ms Crowther says:

"At Manchester, using the approach that we have, a rapport and trust is built up between patients on the segregation unit and the nurse attending daily. This enables her to liaise with the staff and the Listeners to identify problems. Her priority is the mental health of the prisoner in the segregation unit. She has no discipline interest, and is there for continued care when the prisoner leaves the segregation unit."

13.22 In addition, Ms Crowther told the inquiry that since January 2007 the prison has held medical records electronically. This means that they can be accessed by authorised staff at computer terminals in all clinical areas and a business case had been put forward to extend this to the segregation unit. Ms Crowther commented that everything was now documented in one place, there had been no incidents of lost records or documents, there was no problem interpreting handwriting and entries could be audited. Clinical staff attending the segregation unit were no longer dependent on finding the hard copy Inmate Medical Record. The record could be checked beforehand at any authorised terminal or could be accessed by telephoning a member of staff with direct access.

Consideration

13.23 Current Prison Service requirements on prisoners' fitness for adjudication and cellular confinement provide that assessments should not now be made without consulting information from records and that no prisoner should be placed in segregation unless the segregation safety assessment has been completed. Both these new measures, introduced since 1998, might have helped to protect Sonny Lodge.

Findings and recommendation

13.24 Drawing on Dr Wright's advice,

I find that

- There was a systemic failure in the assessment of fitness for adjudication and cellular confinement in that it was made without reference to any history or prior

knowledge of Sonny Lodge. That was not contrary to Prison Service policies in 1998 but it was unsatisfactory. Current Prison Service policy requires a risk assessment, including reference to medical records, before a punishment of cellular confinement is imposed.

13.25 Drawing on Dr Wright's advice,

I recommend that

- The Prison Service urges all prisons, in conjunction with their local primary care trust, to provide dedicated mental health care for segregation units.
- Electronic Medical Information Systems (EMIS) in prisons incorporate provision for clinical staff to have confidential access to medical information at a terminal in the segregation unit.

Chapter 14:

SAFEGUARDS AGAINST SUICIDE AND SELF-HARM (1): PRISON SERVICE POLICIES AND PROCEDURES

Introduction

14.1 The inquiry undertook to examine:

- whether the F2052SH procedure was operated in accordance with Prison Service guidance and whether there are lessons to be drawn about caring for prisoners at risk of self-harm and/or suicide;
- in particular, to examine the response to information from a day centre manager and Sonny Lodge's girlfriend, the knowledge that he had been refused bail, and observations that he was distressed during the adjudication.

14.2 The inquiry's consideration and findings are set out in the next chapter. Chapter 14 contains an account of the relevant Prison Service policies in 1998 and how they have changed since then. It also includes information about the operation of the current policies at Manchester prison and about the Listeners scheme there.

Policies and procedures

Prison Service policies to protect prisoners against suicide and self harm

14.3 The Prison Service has developed systems and guidance to help staff support prisoners against the risk of suicide or self-harm. Approaches have changed over time as more has been learned about how to reduce distress and give help and support to prisoners at risk of suicide and self-harm.

The overall policy framework

14.4 In 1998, the system was explained in Instruction to Governors (IG) 1/1994 and IG 79/1994 *Caring for the Suicidal in Custody* and an accompanying Guide to Policy and Procedures. The Guide drew on a review conducted by the then

Chief Inspector of Prisons[1] and a research report[2]. According to the Guide, the Chief Inspector's report emphasised the importance of relationships (both between prisoners

[1] HM Chief inspector of Prisons, Review of Suicide and Self-Harm, 1990

[2] Research by Liebling A and Krarup H, Institute of Criminology, University of Cambridge, published in1993

and between staff and prisoners) in supporting prisoners. This was supported by the research report, which the Guide said found, among other things, that the risk of suicide and self-harm

"...could be reduced by a range of 'protecting agents' including supportive and helpful staff, constructive activities, family contact, action against bullying and involvement of outside agencies such as Samaritans"

and that

"Above all the vulnerable prisoner needed listening and understanding."

14.5 Key features of the guidance were the F2052SH procedure and the Suicide Awareness Team. The F2052SH procedure is named from the reference number of the *Self Harm at Risk Form* in use at the time. IG 1/1994 says that:

"A Self Harm At Risk Form (F2052SH) will be raised in any case where a prisoner is identified by any member of staff as requiring special care due to possible risk of suicide or self-harm." (IG 1/1004, Part 3, paragraph 2.2(a))

A Suicide Awareness Team was to be formed in every prison to lead and monitor care for prisoners at risk.

14.6 There have been changes since 1998. The Guide was replaced in 2002 by Prison Service Order (PSO) 2700 *Suicide and Self-Harm Prevention*. The system was changed again in 2005, building on lessons drawn from experience and research. The F2052SH has been replaced by a new procedure which is called ACCT (Assessment, Care in Custody and Teamwork) and is described below. The current edition of PSO 2700 dates from October 2007 and is called *Suicide Prevention and Self-Harm Management.*

The system in 1998: F2052SH

14.7 The F2052SH form was an orange booklet. Its distinctive colour made it clearly visible among the other papers in a prisoner's personal record. The front cover states prominently, *"This form may be raised by any member of staff who is concerned about a prisoner."* Guidance for staff covers:

- Identifying the prisoner's needs by listening to the prisoner and showing concern.

- Meeting the prisoner's needs. This included considering all available resources in the establishment and the community and drawing up a support plan, in specific terms, about action to be taken, when and by whom.
- Reviewing the prisoner's needs, through case reviews, including the prisoner, at specified intervals and when certain circumstances changed. Successive case reviews were to involve the same people wherever possible.

14.8 The sections in the form included:

Report by the initiating member of staff

This says the purpose of the form is to ensure that as much help as possible is given to a prisoner during a difficult period when he/she may be at risk of self-harm or following self-harm. It asks the reporting member of staff to explain why they are concerned, to record what the prisoner says about their situation and to suggest what should be done to help.

Initial action by the residential unit manager

The unit manager should speak to the prisoner and initiating member of staff and to health care staff and other staff who may have relevant information, and should check records. The manager should decide how to proceed and record reasons. Unless the prisoner is to be placed in the health care centre, the manager should record what should be done initially to help the prisoner.

Record of case review

The first case review must be held within 72 hours unless the prisoner is in the healthcare centre. The form says that the purpose of a case review is to share information on how the prisoner is coping and reach team decisions on what further action needs to be taken to address underlying needs. Case reviews should normally be conducted in the residential unit (usually a wing) and involve other departments as much as possible. The review coordinator must record the support plan, allocating actions to staff or departments responsible.

Health care assessment

Where the form is opened by a health care officer or nurse, or where a prisoner is referred to healthcare, nursing staff complete an assessment and the prisoner must be assessed by a doctor within 24 hours.

Discharge report

This is to be completed by a doctor when a prisoner is discharged from healthcare and returned to a residential unit.

Daily supervision and support record

This says that the purpose is to report on the prisoner's mood and behaviour and all ongoing action taken to help the prisoner. It includes reporting on the implementation of the support plan decided at a case review and involvement by outside agencies and family.

14.9 When an F2052SH form was closed, the residential unit manager was to sign the form off and the file was placed in the prisoner's personal record. The personal record is held in the prison's central administration unit not on the residential wing.

The system now: Assessment, Care in Custody and Teamwork (ACCT)

14.10 The F2052SH system has been replaced since the events detailed in this report. Implementation of the new policy was phased over 2005-2008. The new system drew on the experience of operating the F2052SH procedure and research on suicidal and self-harming behaviours, including a four-year project (the Safer Locals Programme) about the particular problems in Local Prisons (like Manchester), where large numbers of remand and sentenced prisoners spend short periods of time. PSO 2700 *Suicide Prevention and Self-Harm Management*, as revised and reissued in October 2007, set out the national policy. References below are to the current edition of PSO 2700.

14.11 Certain features of the new policies are of particular relevance to the case of Sonny Lodge.

- **Statement of purpose**

  The policy gives instructions on identifying prisoners at risk of suicide and self-harm and caring for them but it also places *"considerable emphasis on reducing risk by ensuring all prisoners (whether identified at risk or not) receive individual support in managing any problems"* (PSO 2700 Statement of Purpose, page 8). Among the goals of the policy is

  "reduction in distress and improved quality of life for all who live and work in prisons" (PSO 2700 Desired Outcome, page 8).

- **Prison culture**

  The policy states that research evaluating the Safer Locals Programme found that suicide prevention was most effective when prison culture had the following characteristics:

  "staff felt valued, communication was good, prisoners felt safe and there were good staff relationships with senior managers, who were approachable and supportive. In contrast, some prisoners had a 'traditional' or negative culture, where staff relied on overuse of authority, distanced themselves from prisoners, and expressed distrust between uniformed and specialist staff groups. The quality of care for prisoners in these prisons was reduced." (PSO 2700, paragraph 2.1.1)

- **Staff-prisoner relationships**

  Staff are advised that prisoners emphasised the value of having a member of staff listen to them and take their problems seriously. Interviews with suicidal prisoners confirmed that staff who took time to help them were appreciated. Several prisoners who had attempted suicide talked about how they wanted staff to *"talk to them and engage with them, not just to observe them"* (PSO 2700, paragraph 2.2.1*).*

- **Change of status prisoners**

  Reception staff are required to ensure that they talk with prisoners who have had a change of status. Local procedures must make provision for prisoners who have had a change of status without leaving the prison to undergo the equivalent of a 'reception screen' to assess risk of suicide or self-harm (PSO 2700, paragraph 4.8).

- **Positive regimes and purposeful activity**

  Positive regimes are defined as:

  "…those which enable prisoners to engage in activities which reduce distress and potentially reduce rates of suicide and self-harm, for example through improving mood and increasing coping skills and self-esteem. Potentially helpful activities include work, education, structured programmes, art and exercise." (PSO 2700, paragraph 5.1.1)

Paragraph 5.1.4, states that:

"research has indicated that at prison level, lower rates of self-inflicted deaths over time are associated with higher rates of purposeful activity, even when the type of prison is taken into account"

and that

"vulnerable prisoners were significantly less distressed in those prisons where they had less time in cell, higher levels of employment and offending behaviour programmes, and where association was less frequently cancelled".

Paragraph 5.1.5, states that

"Interviews with suicidal and self-harming prisoners confirm their view of the importance of having 'something to do' as an alternative to self-harm."

Segregation

14.12 The policy states that: *"A disproportionate number of prisoners who kill themselves do so in Segregation Units, many within 24 hours of location there."* (PSO 2700, paragraph 8.6.14)

14.13 Prisoners on an open ACCT plan or in the post-closure phase must not be placed in accommodation (such as a Segregation Unit or special accommodation) that reduces their access to social support, other people, activities and stimulation unless, exceptionally, they are such a risk to others that no other suitable location is appropriate and where all other options have been tried or are considered inappropriate (PSO 2700, paragraph 8.6.15).

14.14 Location of an 'at-risk' prisoner in the Segregation Unit must be authorised by the duty governor, who must record in the ACCT document why it was considered necessary (PSO 2700, paragraph 8.6.16). A mental heath assessment must be undertaken within 24 hours (PSO 2700, paragraph 8.6.17). Until then, there must be observations or conversations with the prisoner at irregular intervals five times in every hour (PSO 2700, paragraph 8.7.19).

14.15 Conversations are *"supportive interactions when the member of staff talks with the prisoner. Observations are checks, appropriate when the prisoner is asleep at night."* (PSO 2700, paragraph 8.7.1)

14.16 *"Prisoners who are at risk of suicide and self-harm and are found guilty at adjudication should, wherever possible, have sanctions applied that do not consist of cellular confinement."* (PSO 2700, paragraph 8.6.18)

The ACCT plan

14.17 The F2052SH for prisoners identified as being at particular risk was replaced by a new plan – ACCT (Assessment, Care in Custody and Teamwork). Key features are:

- an individual assessment for every prisoner identified at risk of suicide/self-harm;
- a team of staff trained to conduct semi-structured assessment interviews;
- development of flexible and individualised care and management plans (called CAREMAPS);
- accountable management of care plans through case managers and naming those responsible for specific actions;
- agreed communication and referral protocols linking systems of care for suicide/self-harm with systems for mental healthcare;
- greater emphasis on supporting guidance and training.

14.18 Prison Service Instruction (PSI) 18/2005 which introduced the ACCT plan says that it seeks to promote an emphasis on *"people not processes",* and *"individual care (rather than 'suicide watch')"* (PSI 18/2005, paragraph 5). It is noticeable that the new procedures generally speak of "*individuals"* and "*persons"* where policies formerly said *"prisoners"*.

14.19 As in the F2052SH system, the ACCT form is a booklet with a distinctive orange cover containing guidance and prompts for staff completing it.

Assessment interview

14.20 When an ACCT plan has been opened, an immediate action plan is required for the first 24 hours. The assessor team must be notified and an assessor must interview the prisoners within 24 hours, using an extended interview form containing prompts for the assessor to write notes on the individual's perception of the cause of their distress, recent or previous self-harm, current mental state, current suicidal thoughts and intentions, reasons for living and coping resources, other matters and agreement on action.

Case review

14.21 The first case review must be held within 24 hours of the plan being opened. It must be chaired by the unit manager, who must appoint a case manager of minimum grade Senior Officer or Nurse Grade F. Each case must be treated individually. Care should be multi-disciplinary and reviews should involve people whom the person has contact with and/or who can contribute particular insight to the discussion or who the prisoner feels comfortable with. Examples given are chaplains, members of the prison's independent monitoring board, Samaritans, instructional officers and teachers (PSO 2700, Annex 8G and ACCT form).

14.22 The case review team must engage with the person as much as possible, consider all available sources of information, identify the person's most urgent problems and the activities and people best able to provide support, and draw up a care and management plan (PSO 2700, Annex 8G).

Care and Management Plan (CAREMAP)

14.23 The care planning process emphasises the importance of engaging the person at risk and starting from that person's perspective. The record of the plan prompts case managers to consider:

- Action to disable any suicide plan
- Action to link the person to people who can provide support
- Action to build on any strengths or interests the person may have
- Action to encourage alternatives to self-injury
- Action to reduce emotional pain caused by practical problems
- Action to reduce vulnerability because of mental health problems
- Action to reduce vulnerability because of drug/alcohol problems.

14.24 Plans contain a record of: Issues (problems, resources, risk), Goals, Action required, By whom and when, and the Status of the action (for example, awaiting appointment).

Closing a Plan

14.25 The form says that a significant number of people have killed themselves soon after coming off an F2052SH (the predecessor to ACCT) and identifies ways to try to prevent this happening. During the course of reviews, the person at risk should be encouraged to build up their own support networks and coping strategies. Levels of support should be reduced gradually. An ACCT Plan can be closed only when the review team considers it safe to do so. That is:

- the problems that caused the ACCT Plan to be opened have been resolved or reduced
- the individual is able to cope with any remaining difficulties
- they have access to at least some positive sources of support, through activities or people, and they know who to contact if they need support in future.

Post-closure interview

14.26 A date must be fixed for a post-closure interview. The closed plan remains on the wing until the case manager is satisfied no further post-closure interviews are required. The date of the first post-closure interview is to be decided by the case review team but must be within seven days of closing the plan.

Equipment and the built environment

14.27 PSO 2700 contains policies about the provision of 'safer cells', with furniture and window bars designed to make the attachment of ligatures very difficult. The PSO emphasises that safer cells cannot deal with the problems underlying a prisoner's self-harming or suicidal behaviours and cannot replace a regime providing individualised and multi-disciplinary care for at-risk prisoners (PSO 2700. paragraph 10.1.2).

14.28 The PSO requires all prisons to have local arrangements for staff to carry anti-ligature knives. It states that all *"unified and uniformed staff in closed and semi-open establishments must be provided with and carry on duty their own personal issue cut-down tool. It is <u>not</u> sufficient for tools to be held in a box in the office…."* (PSO 2700, paragraph 11.3.3)

Current practice at Manchester prison

14.29 Manchester prison's current policy and strategy on suicide prevention and self-harm management was adopted in April 2008. It closely follows the national guidance, with the addition of local provision on some aspects.

14.30 The Governor says that active engagement with prisoners thought to be at risk of suicide and self-harm can be a in a variety of forms. All training at Manchester emphasises that staff should be making conversational and interactional entries in ACCT documents.

14.31 The local policy states that during the initial review it must be established whether the prisoner has a family member or another supportive person in the community that can offer support in conjunction with the ACCT plan. The prison has a Prisoners' Family and Friends Helpline for receiving any risk information or concerns about individual prisoners.

14.32 The Governor told us that any information received from outside agencies, eg family, outside probation, courts, solicitors or other sources is recorded then passed to the prisoner's location and the unit manager interviews the prisoner and assesses whether an ACCT should be opened.

14.33 The Head of Healthcare told the inquiry that in the three months from July to September 2008 there had been 17 expressions of concern from prisoners' friends or family: eight were through the visits booking line, seven through the safer custody manager's office and two through the visitors' centre.

14.34 The Governor called the post-closure phase a *"parachute period"* where the individual has the opportunity to reduce their dependence on the ACCT plan support gradually, with support structures still in place. After the post-closure interview, the plan is sent to the Safer Prisons Coordinator who carries out a post-closure questionnaire with the individual about the support that was offered and to identify any strengths or weaknesses in local ACCT procedures.

14.35 In 2007, 407 ACCT documents were opened at Manchester, averaging 33 per month. Incidents of self harm totalled 275 in 2007, an average of 22 per month. In 2008, 251 ACCT documents were opened in the period up to 25 September. There had been 117 incidents of self harm, an average of 14 per month.

14.36 In oral evidence to the inquiry, Mr Vince said that he believed that the significant change between 1998 and 2008 was that suicide and self-harm prevention has developed to become an ingrained part of what prison officers do. This injected *"the qualitative element"*. Staff could:

"complete the paperwork but if they don't actually care what they're doing and if they're not actually treating people as individuals and looking after them then the paperwork means nought."

14.37 In accordance with the PSO, Manchester's policy provides that all personnel who have contact with prisoners must carry a personal cut-down tool. Line managers are required to ensure that staff are in possession of all personal issue equipment at commencement of duty.

Listeners

14.38 Most prisons in England and Wales have a Listener Scheme. This is a peer support scheme in which selected prisoners are trained and supported by the Samaritans to listen in complete confidence to their fellow prisoners who may be experiencing feelings of distress or despair. A Listener scheme has operated at Manchester since 1994. Listeners offer confidential emotional support to prisoners in distress, aiming to allow time and space for prisoners to open up and discuss their feelings in confidence.

14.39 The inquiry obtained evidence about how the scheme operates currently from Ms Crabbe, the Samaritans Deputy Director for Outreach and Prisons in Manchester and Salford. Ms Crabbe told us there were currently 18 trained Listeners in Manchester. This is a ratio of 1 to 70 prisoners so less than the recommended level of 1:50. However, the Listening scheme at Manchester saw an increase in contacts from 459 to 1727 in a six month period in 2008. Ms Crabbe attributed this to an improved induction programme whereby prisoners are encouraged to seek a Listener if they are in emotional distress. She commented: *"Sometimes Listeners are the very first people who have ever offered to sit and listen in a non judgemental way."*

14.40 Prisoners can approach Listeners direct provided there are Listeners based on the wing. Otherwise access can be arranged through a staff member. Prisoners may also request the direct telephone line to the Samaritans service outside the prison. There is one cordless phone on each wing for this purpose.

14.41 The inquiry asked whether there were any problems encountered at Manchester that impact on the Listener service. The organisers spoke positively of the relationship with prison staff generally and the Safer Custody team in particular but said there were some logistical problems.

- It appears to take a long time for security/probation to clear and check potential Listeners for Samaritan selection. This delays training. It is important to train new Listeners to maintain sufficient numbers as experienced Listeners are transferred or released.
- Sometimes there will be five Listeners on one wing and no Listeners on another which may mean that a Listener cannot be provided when required as it is difficult to transfer a Listener, especially during the night period.
- Samaritans telephones are handed out when requested but as most cells have double occupancy prisoners cannot speak to the Samaritans branch confidentially.

14.42 The Safer Prisons Coordinator at Manchester Prison, Mr Dugdale, provided information to the inquiry about the rigorous selection and training procedure for Listeners. Coupled with the transient nature of the prisoner population at Manchester, this presents challenges for maintaining a full complement of Listeners. For example, qualification as a Listener cannot stand in the way of a progressive move to another prison to assist rehabilitation and reduce risk to the public. Another factor was the extensive security vetting required for members of the Samaritans prison team. This currently took between six and 12 weeks. That had reduced the numbers of Samaritans available so they had been able to run only one training course for Listeners in each of the last two years, whereas previously they had been able to run two each year. Mr Dugdale said that the prison and the Samaritans team were working together to try to attract more Samaritans to the prisons team.

CHAPTER 15:

PREVENTING SUICIDE AND SELF HARM (2): CONSIDERATION AND FINDINGS

Consideration

15.1 The Prison Service has a duty to take reasonable care to protect the life and well-being of prisoners in its custody. There are reasons why many people in prison are especially vulnerable. They include mental ill-health and other medical problems, drug or alcohol dependence, the experience of withdrawal from dependence, the experience of confinement, things that happen in prison, being cut off from family and friends and other kinds of support, problems prior to imprisonment, being unable to attend to personal problems outside the prison.

15.2 During his time in prison Sonny Lodge was at times identified as being at risk of suicide and self-harm and on one occasion he deliberately lacerated his arms. At the time of his death he was not thought to be at risk and there were no special safeguards to help or protect him. This chapter examines:

- compliance with the F2052SH system in force at the time
- the limitations of that system
- problems in identifying risk
- the response to Ms A's warnings
- the importance of sharing information
- what would have been different if an F2052SH had been opened
- how practice would have differed under the current ACCT system.

Compliance with the F2052SH procedures at the time

15.3 The inquiry examined whether the F2052SH procedure was operated in accordance with Prison Service guidance and appropriately and whether there are lessons to be drawn.

15.4 So long as Sonny Lodge was subject to an F2052SH staff maintained special observation of him and the plans were operated seemingly conscientiously and broadly, though not entirely, in accordance with guidance and the usual practice at the time. It was to the credit of staff at Risley that a plan was opened when Sonny Lodge was admitted and, at Manchester, that they kept the plan open initially despite Sonny's

apparent assurances that it was unnecessary. A nurse at Garth tried to arrange an early visit by Sonny's girlfriend or sister. That was sensible and kind.

15.5 However, there were departures from good practice. For example:

- There is no entry at Risley for initial action by the residential unit manager.
- The first case review at Risley was held after one week, not within 72 hours as required. There was no support plan until the review.
- There appears to have been no initial plan by the unit manager or a support plan while the F2052SH was open at Manchester.
- Case reviews at Risley and Manchester did not involve any specialist staff but seemingly wing officers without particular knowledge of Sonny.
- The frequency of observations was generally not specified and is not consistent.
- A preponderance of the entries at Manchester record periodic observation overnight when Sonny was asleep.

The limitations of the F2052SH system

15.6 Entries in the F2052SH form illustrate the limitations of the F2052SH system which the new ACCT is meant to address. For the most part they give precious little information and there is little evidence of engagement with Sonny Lodge and his problems.

15.7 The F2052SH system had fine aspirations. It was ground-breaking. It provided a structure for paying special attention to prisoners thought to be at risk and may have saved many lives. The preamble to the policies was about supportive relationships and sharing information but too often entries in the daily supervision and support records indicated observation not interaction and provided no significant information for colleagues. At Manchester and also at Risley it is not altogether clear what the support amounted to. It fell well short of the individualised care plan addressing individual problems that the ACCT system now aims to provide.

Problems in identifying risk

15.8 Dr Wright spoke of the difficulty of predicting suicidal intent from one-off interactions. Stated intention to a stranger cannot be a reliable guide. What Sonny Lodge reportedly told Healthcare Officer Stell and Officer Sanderson about his state of

mind in the last week of his life is very different from what he wrote in letters. Moreover, suicidal behaviour may be impulsive. Dr Wright advised that assessment by a clinician of fitness for cellular confinement or other prison procedure on the basis of a brief conversation is of dubious value. He argues the need for a continuous therapeutic relationship. The best defence against suicide in prison is supportive interaction through consistent relationships.

The response to Ms A's warnings

15.9 Dr Wright concluded that opportunities to prevent Sonny Lodge's suicide were missed in the final days of his life, in particular in response to the telephone calls from his girlfriend. I agree. In the final week of Sonny Lodge's life, Ms A did what she could to protect Sonny. Yet no F2052SH was opened; individuals who did not know him made judgements in ignorance of information known to others; information was not sufficiently shared or always recorded in the place where it would be read when needed; some information that was recorded - in the IMR and history sheets - was not taken into account.

15.10 HCO Stell, Officer Sanderson, Ms Lorimer, Mr Johnson and Captain Palmer all spoke with Sonny Lodge in the last days of his life because of concerns about his welfare. On Tuesday 25 August, after Sonny Lodge was refused bail by the magistrates, Officer Sanderson's record in the observation book says, in terms, that his girlfriend said Mr Lodge had a history of self-harm. Officer Stell's entry in the medical record says Ms A was worried Sonny might harm himself. Ms Lorimer was aware that Sonny Lodge was depressed, that his girlfriend was concerned and that there had been at least one previous incident of serious self-harm. Captain Palmer saw Mr Lodge at Ms Lorimer's request but did not recall that he had been alerted to any risk of self-harm. Mr Johnson says that on Friday Ms A did not refer to self-harm but he and the staff in the segregation unit spoke about whether Sonny Lodge might be at risk of suicide.

15.11 People knew that Sonny's girlfriend was worried about him but, in each case, the staff member decided not to open an F2052SH. Each showed concern for Sonny and was experienced in the prison environment. No-one identified Sonny's vulnerability. That is not to condemn the individual staff concerned. Unfortunately, it is not uncommon for prison staff to be working with prisoners who have a history of self-harm. I have also been told that it is not an uncommon occurrence for families to register concerns. In a place where so many needy, damaged people are concentrated, the threshold for

flagging special risk may be too high. What are staff to do? If they are too ready to label, then the resource available for the most vulnerable is spread more thinly. Staff have to make judgements from limited evidence. They must also pay attention to what a prisoner says of himself. It seems Sonny Lodge told the officers on Tuesday that his girlfriend was mistaken.

15.12 Physical surroundings may militate against prisoners' disclosing distress. Consider the circumstances of the conversations with the two officers on Tuesday and also with Captain Palmer on Thursday morning: called out of the holding room into reception; at the wing office, *"on a light note"*, when Sonny came to collect his canteen; out of the cell on to the landing in order to talk more privately. Despite the staff members' best efforts to provide a degree of privacy, the conversations were all held with Sonny in relatively public places and probably standing up. The officers and Captain Palmer said there was nothing in Sonny's demeanour to indicate a need for a more secluded interview. But can that really be a reliable way of finding out whether someone who is a stranger to you is battling with despair sufficient to end their life?

15.13 The chaplains offered support and concern but were more or less strangers to Sonny Lodge. Hindsight shows they did not judge the risk correctly. That does not mean their judgments were wrong at the time or from what they knew. But there was relevant information they did not know about; and I question whether they sufficiently shared what they knew. On Wednesday, Ms Lorimer knew Sonny's history of self-harm, that he sometimes had thoughts of suicide and that Ms A was concerned for his welfare. Ms Lorimer was clearly an experienced and caring counsellor but the logistics of the prison were not conducive to a continuing counselling relationship. Captain Palmer's conversation with Mr Lodge next day was supportive but of a different order. Mr Johnson told the inquiry that on Friday he did not know that Sonny had self-harmed in the past or that, earlier in the week, Ms A had specifically said she was concerned Sonny might do himself harm.

The importance of sharing information

15.14 Risk assessment is not an exact science or a one-off event. It is a process in which information may accumulate. The chaplains did not know that two officers had spoken to Sonny on Tuesday evening after Ms A telephoned to say she feared he might self-harm. The discipline staff did not know that she telephoned again or of the chaplains' involvement on Wednesday and Thursday. Ms Lorimer arranged for her

colleague to see Sonny Lodge on Thursday and Father McCann drew in Mr Johnson on Friday. Each knew only part of the picture.

15.15 In the absence of the consistent relationships that Dr Wright considers the best defence, information sharing becomes critical. In a local prison with a rapidly changing population, consistent use of records has to act to some extent as a proxy for consistent relationships. It needs to be systematic so that essential information is not lost along the way. Information that is recorded needs to be used.

15.16 There were numerous occasions in the last week of Sonny Lodge's life when information was not recorded, or not recorded in all the right places or not referred to:

- The prisoner escort records that accompanied Sonny Lodge to and from Liverpool referred to a risk of suicide and self-harm but no cognisance seems to have been taken of them in reception when he returned to Manchester on Tuesday evening despite Ms A's telephone call. HCO Stell did not see the records and he did not know that Sonny Lodge had self-harmed in prison.
- Ms Lorimer decided to keep her concerns within the chaplain's team but it appears that no record was made and there was no plan for further support after Captain Palmer's visit.
- Officer Sanderson is to be commended for his notes in the wing observation book on Tuesday evening but he did not make a note in Sonny Lodge's history sheets. The notes contained significant information that should have been recorded in the history sheets as well as the observation book even though Officer Sanderson judged there was no immediate cause for concern.
- SO Nuttall did not read the observation book when he came on duty on Thursday evening. It appears to have been customary at Manchester at the time to rely on oral handovers.
- An entry was made in the Inmate Medical Record (IMR) in the evening of Thursday 27th when Sonny was examined after the incident in the cell before transfer to the segregation unit. The entry immediately above was about Ms A's warning that Sonny might harm himself. It is extraordinary that

this was either not read or prompted no concern, even though Sonny was going into segregation.

- The inquiry has not established who completed the conduct report for the adjudication. It refers to the entries for infringements on the wing but not to the entry from 27 July about a serious act of self-harm, even though the history sheets were only four pages long.

15.17 Staff who were responsible for Sonny Lodge in the segregation unit and at the adjudication did not know of his history of self-harm nor his girlfriend's fears for his life. Sonny showed distress during the adjudication, but we are told this was not to an unusual degree. It says something about the environment and its impact on prisoners if tearfulness among grown men in adjudications was not unusual.

What if an F2052SH had been opened?

15.18 What if an F2052SH had been opened on Tuesday or Wednesday? Sonny would have come to the attention of the senior officer coming on duty at the start of a shift. It seems unlikely that he would have been singled out for loss of association and searching in the way that happened. Or, if he had been, staff would have been alert to the need to check his welfare. Officer Bowcock would surely not have berated Sonny Lodge about the rules if he had known that he was identified as at risk of suicide. It seems unlikely that there would have been cause for Sonny to be placed in segregation or charged under the Prison Rules but, if there had been, those who were charged with his care would have taken special precautions.

15.19 If an F2052SH had been opened in the healthcare centre on Thursday as a result of the entry in the medical record, segregation staff and the medical officer would have been aware of it, and it is unlikely Governor McColm would have placed Sonny in cellular confinement.

Would the current system make a difference?

15.20 It is instructive that Sonny Lodge committed a serious act of self-injury the day after the first F2052SH was closed, and seemingly a dangerous offence with a staple gun only four days after the closure of the plan at Manchester. Both demonstrate the value of the period of further review after the closure of a care plan – what the Governor of Manchester called a 'parachute period'. The ACCT system has introduced this.

15.21 ACCT also requires a risk assessment when a prisoner's status changes and it states that cellular confinement should not normally be given to prisoners on an ACCT care plan.

15.22 The ACCT system appears to offer a significant advance on the F2052SH arrangements. The care planning approach provides a tool for identifying and responding to specific individual need. There is a tapering of special support after a plan is closed. Special safeguards apply when prisoners who have been considered at risk are considered for segregation or when they change status, as Sonny Lodge did when he became a remand prisoner on the last day of his life. There is an emphasis on support from people both inside and outside the prison. Manchester prison has a family helpline and a requirement that concerns expressed by people outside the prison are systematically assessed. The Prison Service has shown a commitment to learning from past tragedies and has invested substantial resources in the strategies for preventing suicide and self-harm.

15.23 Identifying individuals at risk and responding to their needs is one important strand of protection against suicide. But distinguishing individuals at special risk is always going to be imperfect, especially in the local prisons where large numbers of prisoners spend short periods and are not well known to staff. The underlying basis for protection against suicide and self-harm must rest in the culture of the prison, that is in relationships, practical support for prisoners and active regimes. That is not a new insight. It was clear from the studies on which the F2052SH system was based and it forms the basis for the ACCT procedures. The challenge for prison managers and staff is to apply the theory in practice.

Findings

15.24 I find that

- There was a systemic failure to protect Sonny Lodge in the last days of his life in that:
    - Insufficient regard was paid to Ms A's warnings.
    - Judgments were made not to open an F2052SH, in ignorance of material facts that ought to have been known.
    - Information was not always recorded so that it was available to others.

- Where information was available, in the Inmate Medical Record, the escort records, the observation book and the history sheets, it was either not referred to when, reasonably, it should have been, or it was not taken into account, when it ought to have prompted special protection.

- If information had been shared properly, an F2052SH would have been opened. This would have altered the course of events and would probably have prevented Sonny Lodge taking his life when he did.
- The current arrangements for safeguarding prisoners against suicide and self-harm represent a significant advance on the F2052SH system. I note in particular: the care planning approach, the emphasis on interaction, not observation, and on identifying and responding to specific individual need; the tapering of special support after a plan is closed; the requirement that concerns expressed by people outside the prison are systematically assessed.
- The best defence against suicide in prison is a positive prison culture which values prisoners as complex individuals, pays heed to the concerns of prisoners' family and friends, offers practical support with prisoners' problems and recognises that prisoners may not readily disclose their feelings of distress.

Chapter 16:

THE INQUIRY'S CONSIDERATION AND FINDINGS ABOUT THE INCIDENT AT WHISTON HOSPITAL AND THE PRISON SERVICE'S RESPONSE TO IT

Introduction

16.1 The inquiry undertook to examine the circumstances of the incident at Whiston Hospital which led to Sonny Lodge not being released on 28 August. In particular, the inquiry undertook to examine whether the Prison Service acted or ought to have acted on concerns expressed by a governor at HMP Garth and the Prison Service investigation. Findings about the incident are in paragraph 16.8. Findings and recommendations about the Prison Service's response to the incident are in paragraphs 16.20 and 16.21.

Consideration: what happened at Whiston?

16.2 There is no conclusive evidence of what happened in the toilet cubicle. At the adjudication that was opened and adjourned at Garth prison Sonny Lodge pleaded guilty to a charge of assaulting Officer Brownley by pushing him backwards. The critical issue is why Sonny Lodge pushed Officer Brownley. Officer Brownley says that it was in response to his instruction to put out the cigarette. The record of Sonny Lodge's interview with the police is not available but he reportedly told others that he put the cigarette to his mouth and the officer hit him in the face then held him round the neck.

16.3 Sonny Lodge was not unwilling to admit to wrongdoing. He was not known to have any significant propensity for violence though he could be abusive and was reported to have been banned from a drugs service for threatening behaviour. Sonny Lodge admitted pushing the officer but when he was charged with grievous bodily harm, he apparently felt a keen sense of injustice. Mr Lodge might have been acting in self-defence, against an actual or threatened assault on his person. His claim that he put the cigarette to his mouth for a last draw has a ring of truth. Governor Halliwell, unprompted by any prior knowledge, believed Mr Lodge was telling the truth. There was no evidence that Mr Lodge sought any advantage from his allegation that Officer Brownley assaulted him. But he was said to have been in an agitated and angry state. That might have made him reckless. He might have pushed the officer away in resentment at the instruction or at the officer's intruding upon him in the toilet cubicle. Sonny's accounts of what happened may have been embellished over time or reported inaccurately by others.

16.4 The evidence of Officer Clucas, Mr Routledge and Mr Brownley is consistent in saying that Officer Brownley came out of the cubicle, propelled by force, only seconds after Sonny Lodge entered it. That allowed little time for de-escalation or the suggestion of going outside to smoke. Moreover it is not clear why Officer Brownley found it necessary to move forward into the cubicle to give his instruction.

16.5 The inquiry has also received circumstantial evidence. The bruise on Sonny Lodge's neck might have occurred in the struggle that followed the incident or on another occasion but it is consistent with Sonny's account in a letter, as reported by Governor Halliwell, and later by the chaplains. There is no record of any visible injury consistent with Sonny's claim in the letter that the officer hit him in the mouth but that does not show the claim is false.

16.6 Mr Brownley's previous disciplinary offence, resorting to direct action to enforce the rules, concerns about his performance thereafter, and the rumours circulating in the prison that very week raise uncomfortable questions about his conduct. In her evidence, Governor Williams was clear that she had spoken to Mr Brownley about the rumour that he would engineer an assault to go on sick leave. It is a long time since the incident occurred, but it was surprising that Mr Brownley had no recollection of being informed about the rumour or of his application to transfer to Manchester prison.

16.7 The inquiry has no authority to try Sonny Lodge or Officer Brownley on the charge of assault. The inquiry draws conclusions on the balance of probabilities not the criminal standard of beyond a reasonable doubt. The inquiry has insufficient evidence to speculate about the verdict that a court might have reached on the charge against Sonny Lodge. On behalf of Mr Brownley, Counsel has argued persuasively that the more serious the criticism, the greater the weight of evidence required to support it. I agree.

Findings about the incident

16.8 I find that:

- At the time of the incident at Whiston Hospital, there was in existence a rumour that Officer Brownley would engineer an assault by a prisoner and Governor Williams spoke to Officer Brownley about it.
- At the time of the incident at Whiston Hospital, Officer Brownley had a pending appeal against refusal of an application for a transfer to Manchester prison.

- Despite these findings, there is insufficient evidence to conclude, on the balance of probabilities, that the incident in the toilet cubicle was premeditated or contrived.
- Sonny Lodge's behaviour in the waiting area at Whiston hospital was truculent and challenging.
- Officer Brownley's determination to enforce instant compliance with the hospital 'no smoking' policy was overzealous and he sought to enforce his instruction without the skill and sensitivity that could reasonably be expected of a professional officer.
- The inquiry finds on the balance of probabilities that Mr Lodge pushed Officer Brownley away in reaction to the officer's unjustified and inappropriate movement towards him.
- The inquiry is unable to conclude from the evidence available whether or not Officer Brownley laid hands on Mr Lodge before he was pushed.

Consideration: the Prison Service's response to the incident

16.9 Given the information known to Risley prison about the serious incident at Whiston Hospital, it is extraordinary that no action was taken to investigate what happened or even to ensure that the required records were completed.

16.10 There was a failure to complete appropriate paperwork. Policy at the time required Use of Force statements to be completed whenever officers used control and restraint. An F213 Injury to Inmate form should have been completed with reference to the bruise on Sonny Lodge's neck that is recorded in his medical record. Completion of an F213 would have required a brief report of the circumstances in which the injury was sustained so might have prompted further inquiry about the circumstances of the injury.

16.11 There was no Prison Service investigation of the incident on the grounds that the case was in the hands of the police. It is not clear how the police came to pursue it. Although he was the complainant, Officer Brownley told the inquiry that it was not his initiative. Risley prison apparently already believed on 28 June that the police were to formulate charges.

16.12 The case seems not to have been a high priority for the police. The incident occurred on 27 June. Mr Routledge was interviewed on 8 July and Officer Brownley on 4

August. Mr Clucas had not been interviewed at the time of Sonny Lodge's death. Mr Lodge was interviewed on 24 August but, according to his legal representative, that happened only at her prompting, as he wanted the matter dealt with before his release date. It is not unusual for prisoners to want to expedite outstanding cases so that time on remand runs concurrently with an existing sentence.

16.13 The information about Officer Brownley's disciplinary history, about the rumour circulating in the prison at the time, and about Governor Halliwell's concern might have affected the decision to charge Sonny Lodge with grievous bodily harm. It could certainly have been material to his defence. The information was not disclosed to the police, who had no reason to pursue lines of inquiry about Officer Brownley's character. Not having been disclosed to the police, it is unlikely it would have come to the attention of the prosecuting authorities or have been disclosed to Sonny Lodge's defence.

16.14 Since these events, the then Governor of Risley has died, so the inquiry could not explore his reasoning. Evidence from Governor Williams was that the Governing Governor wished to leave the matter entirely in the hands of the police, although she expected the police to have access to all the relevant information.

16.15 Prisoners sometimes say that their complaints of unprofessional conduct by staff are referred to the police in order to neutralise them. Something that might be a minor incident in the street and rank low in police priorities may be a serious allegation in the context of the powers exercised by staff in a prison. On the other hand, the Prison Service might be equally open to criticism for internal investigation of serious allegations.

16.16 In this case the allegation was of an assault by a prisoner on a member of staff not an allegation by a prisoner, but the Governor's decision meant there was no Prison Service investigation of possible serious misconduct by a prison officer, even though concerns had been raised by two governors acting independently and relying on separate sources. By contrast, the assault on a prisoner for which Officer Brownley was disciplined previously was not referred to the police. Through Counsel, Mr Lodge's family expressed astonishment that a prison officer could keep his job after assaulting a prisoner. I share their concern. Officer Brownley's subsequent retirement was agreed apparently without investigation of the incident giving rise to his disability. That invites the unfortunate perception that it was not inconvenient for the Prison Service for an officer with an embarrassing disciplinary record to retire by consent.

16.17 The inquiry was told that prisoners may resort to various avenues of complaint outside the prison, but it is also the case that there are impediments, including access to resources, limited literacy, limited educational and social competence and fear of reprisals, which inhibit many prisoners from making use of them. The existence of complaints procedures does not absolve the Prison Service from responsibility for ensuring that concerns about officers' conduct are properly investigated, in full knowledge of the relevant facts, either by the police or within the service.

16.18 The inquiry asked the Prison Service whether the information known to governors at Risley should have been made known to the police. The Prison Service says that there are now systematic arrangements for the recording and evaluation of information received alleging wrongdoing by staff and that it is a matter for the judgment of the Governor as to whether such information should be disclosed to the police.

16.19 Because the police file had not been closed, the Prison Service investigators examining the circumstances of Sonny Lodge's death did not interview those involved in the incident at Whiston. However, the report commented on the incident and expressed concern about Officer Brownley's *"rigorous enforcement of the 'no smoking' policy … towards a prisoner in a state of mind to lacerate both forearms".* Governor Williams, who was head of residence at Risley until August 1999, told the inquiry she had not seen the Prison Service investigation report until the present inquiry sent it to her. I do not know whether it was sent to Risley.

Findings about the Prison Service's response

16.20 I find that:

- Notwithstanding the police investigation, prison managers should have ensured that use of force records were completed and, as a matter of routine, that an incident involving the use of force was investigated.
- The information about Officer Brownley's past disciplinary offence and the rumour circulating in the prison were material considerations that the prison ought to have disclosed to the police investigating Officer Brownley's complaint that Sonny Lodge assaulted him.

Recommendations

16.21 I recommend that:

- the Prison Service considers issuing further guidance on disclosure in cases where the police are investigating allegations of assault involving prisoners and prison staff.
- In particular, where the Prison Service declines to investigate possible misconduct by staff because of a related police investigation, I recommend that there is a presumption that information that would have been material to a conduct investigation should be disclosed to the police.
- I recommend that the Prison Service ensures that reports into the circumstances of a death in prison are brought to the attention of all the establishments mentioned in the report's findings or conclusions so that any appropriate action can be taken and any lessons learned.

Chapter 17: TRANSFERS, WING AND CELL MOVES, AND THE WING BASED DISCIPLINARY SYSTEM

Introduction

17.1 The inquiry examined:

- the reasons that Sonny Lodge was frequently moved, the regimes he experienced and whether these may have contributed to his vulnerability to suicide and/or self-harm;
- the impact of the wing-based disciplinary system on Sonny Lodge and whether this may have contributed to his vulnerability to suicide and/or self-harm.

Consideration

17.2 After induction, Sonny Lodge was based in E, H, K and G wings during his period at Manchester. After the alleged assault on G wing on 27 August he spent the night in the segregation unit.

17.3 Dr Wright, the clinical adviser to the inquiry, suggested that cell moves might have contributed to instability for Sonny Lodge. Referring to the theory that attachment to a social setting and a place contributes to mental health and a sense of well-being, Dr Wright said that removal from a setting that has become familiar can present a challenge to psychological health.

17.4 SO Nuttall and the Governor of Manchester indicated that the number of moves experienced by Sonny Lodge was not unusual for a short-term prisoner in a local prison where the establishment is juggling high turnover of prisoners to and from the courts. In their view, short-term prisoners do not become attached to their cells in the way long-term prisoners do. That may well be so, as a matter of degree, but cell moves, especially to share a space designed for one prisoner and with an unscreened toilet, with yet another, usually unchosen, cellmate must be one of the unpleasant experiences of prison. According to Sonny Lodge's cellmate on G wing, he asked for Sonny to share his cell because they were friends outside. If that is the case, the arrangement suggests a kindness by a member of staff.

Moving from E wing

17.5 The inquiry has found no evidence that the moves were malicious. The move from E wing resulted from an adjudication in which Sonny Lodge was given a severe

punishment for an offence of endangering health and safety by misuse of equipment in a prison workshop. There are no longer any records of the circumstances of the offence but it might be said that Sonny Lodge had only himself to blame.

17.6 However this incident, occurring only four days after closure of an F2052SH, profoundly affected his subsequent experience at Manchester prison. He lost his prison job, and spent a week on the wing for prisoners on basic regime, with

- no tobacco
- no money to buy anything
- no association
- no radio
- no occupations in cell
- no publications and
- no possessions in cell,

even though the Prison Discipline Manual said that notebooks, drawing books, radios, education and purchase of stamps and phone cards should not normally be withdrawn.

17.7 The offence may well have been serious but, in my view, a punishment imposing this degree of deprivation borders on the inhumane, no matter how grave the offence or how mentally robust the prisoner concerned. What would be the effect on anyone of confinement for all but an hour's exercise a day (weather permitting) with no means of occupation? It is difficult to see that this can have any constructive penal purpose. Moreover, Sonny Lodge was not mentally robust. Only four weeks before, he had severely lacerated his arms and the F2052SH had been closed only four days earlier.

K wing

17.8 After the week on H wing, Sonny was moved, not back to E wing as had originally been intended - with specific reference to the recent F2052SH (see paragraph 7.34 above) - but to K wing. There is no record in the history sheets as to why the previous entry was disregarded. It was a fateful decision. After he left E wing, Sonny Lodge spent his time at Manchester in locations with an impoverished regime, little constructive occupation, and, at least on K wing, a poor relationship between staff and prisoners. After the entry of 25 July, about moving back to E wing after the seven days'

punishment, there is no evidence that wing staff took any further account of Sonny Lodge's recent history of self-harm.

17.9 Before and after this time, HMCIP expressed serious misgivings about the regime on K wing, the relationships between staff and prisoners and the wing-based disciplinary system. Prison officers were able to exclude prisoners from association, without due process, in circumstances outside those specified in Standing Order 4 and Prison Rule 45, and with little evidence of managerial oversight. Sonny Lodge was locked up for association periods under the scheme on at least three occasions and, from his letters, there may have been others. According to the records, Sonny's behaviour deteriorated; his letters became increasingly hostile to prison staff and he clearly found K wing stressful. It is to SO Nuttall's credit that he recognised this and sat down with him to talk about it.

17.10 Sonny Lodge's account of life on K wing and the descriptions by HMCIP represent two sides of the same coin: distant and mutually hostile relationships between prisoners and staff, with small incidents tending to escalate and prisoners resenting what they saw as arbitrary abuse of authority – or wind-ups. That is not a healthy regime. It is a far cry from the aspirations of the 1994 Guide to preventing suicide and self-harm, which emphasised supportive relationships, helpful staff, constructive activities and above all listening and understanding. Still less did it meet the key features of the current ACCT guidance to reduce risk by ensuring all prisoners (whether identified at risk or not) receive individual support in managing any problems.

Prison culture

17.11 The ACCT guidance and the Safer Locals Programme emphasised the need to reduce distress for all who live – and work – in prisons: for staff as well as prisoners. They describe a healthy prison culture as one in which

"staff felt valued, communication was good, prisoners felt safe and there were good staff relationships with senior managers who were approachable and supportive".

17.12 This is contrasted with some prisons with

"a 'traditional' or negative culture, where staff relied on overuse of authority, distanced themselves from prisoners and expressed distrust between uniformed and specialist staff groups. The quality of care for prisoners in these prisons was reduced." (PSO 2700, paragraph 2.1.1)

The description of a negative culture appears to correspond with HMCIP's picture of life on K wing.

Fair and active regimes

17.13 The Prison Service understands the value of fair and active regimes. As long ago as 1984, a report of the Control Review Committee focussed on the importance of activity within prisons and concluded that the prison system should be based on *"individualism, relationship and activity"*.[1] Using the term *"dynamic security",* the report argued that planned activity, tailored to prisoners' wants and needs, and the development of good relationships between staff and prisoners, were necessary for both safety and security in closed establishments.

17.14 The Woolf Report about the disturbances at Manchester and other prisons in 1990 concluded that justice in prisons was an important element in maintaining order through appropriate relationships between staff and prisoners.[2]

17.15 In 2000 the Prison Service commissioned research from the University of Cambridge Institute of Criminology about measuring the quality of prison life. The research included examination of prisoners' levels of distress and, conversely, well-being. It was found that levels of distress were linked to aspects of the prison environment. There were significant differences between prisons. The measures of the prison environment that contributed most directly to reducing or increasing distress were perceived physical safety, respect, relationships and fairness, dignity, frustration, clarity, security and order, and family contact. Levels of distress provided reasonable indications of levels of suicide risk in each prison over time. This is consistent with Dr Wright's advice to the inquiry that a sense of being treated unfairly may be harmful to psychological health.

Promoting healthy prisons

17.16 The importance of prison culture has been recognised by those who monitor and manage prisons.

17.17 HMCIP has adopted four *"healthy prison criteria"* as the key elements in its inspection model. The criteria are: Safety – that prisoners, even the most vulnerable, are

[1] Home Office (1984) *Managing the Long-term Prison System: The Report of the Control Review Committee*, London: HMSO.

[2] Home Office(1991) *Prison Disturbances April 1990: Report of an Inquiry by the Rt. Hon. Lord Justice Woolf and His Honour Judge Stephen Tumim, (The Woolf Report*), London: HMSO.

held safely; Respect – prisoners are treated with respect for their human dignity; Purposeful activity – prisoners are able, and expected, to engage in activity that is likely to benefit them; Resettlement – prisoners are prepared for release and helped to reduce the likelihood of reoffending.

17.18 The Director General appointed in 1999, and his successor, have repeatedly championed a *'decency agenda'*, that prisons should be fair, humane and reformative places. In a speech to the Prison Service Conference in 2001 the then Director General, Martin Narey, stated:

"I am not prepared to continue to apologise for failing prison after failing prison. I've had enough of trying to explain the very immorality of our treatment of some prisoners and the degradation of some establishments…it's a matter of caring, a matter of determination and, I accept, not a little courage in taking on a culture in all too many places which we have allowed to decay...."

"The choice is straightforward. We take on the challenge. We make a reality of the rhetoric of decency and dignity. Or we accept the unacceptable. We tolerate filth, appalling healthcare, treating prisoners as a sub-species, doing virtually nothing to prepare them for release."[1]

17.19 The inquiry asked the Prison Service whether it accepted that levels of prisoner distress and rates of suicide are linked in part to levels of fair and respectful treatment. The reply quotes the following from the current corporate business plan:

"The decency agenda remains absolutely crucial to the service's development and the delivery of decency underpins all its other work. In particular it is a vital component of reducing the rate of suicide…"

Findings

17.20 I find that:

- The punishment imposed at the adjudication increased Sonny Lodge's vulnerability through confinement without means of occupation or distraction.
- To go back on the decision to return Sonny Lodge to E wing after the seven days' punishment was either a mistake or it was a deliberate decision for which reasons should have been recorded.

[1] quoted in Liebling, A (2008): *Prisons and their Moral Performance,* Oxford p.39.

- The regime on K wing was unsatisfactory. It increased Sonny Lodge's alienation and distress.
- The wing-based disciplinary system gave unfettered authority to individual officers to impose penalties without due process that reduced prisoners' opportunities for social interaction and supportive contact with families. It was unfair and may have been unlawful. It stopped in October 1999.
- Loss of association under the wing-based disciplinary system increased Sonny Lodge's isolation and so may have increased his vulnerability.

Chapter 18: WAS SONNY LODGE VICTIMISED?

Introduction

18.1 The inquiry examined:

- whether there were grounds for Sonny Lodge's belief that he was being victimised as a result of the incident at Whiston Hospital or for other reasons;
- and what role, if any, this played in the circumstances of his death.

18.2 This chapter includes consideration of the evidence about Sonny Lodge's claims that he was victimised and about his character and credibility.

Consideration

Sonny Lodge's claims he was victimised

18.3 Sonny Lodge told several people that he was victimised by prison staff at Manchester. He believed he was singled out because he was said to have assaulted a prison officer.

18.4 In a letter to his girlfriend from the hospital wing at Garth, Sonny Lodge said that until the allegation of assault at Whiston hospital he had never been 'nicked' for misbehaviour in prison. The Manchester chaplain, Mr Johnson, said Mr Lodge told him he always pleaded guilty when he had committed an offence. The inquiry has not been able to verify these two claims but has no information to the contrary.

18.5 With the exception of the incident at Whiston Hospital, there is no record of any complaint about Sonny Lodge's behaviour at Risley, Garth or Manchester until after his induction at Manchester. Nor does Mr Lodge make any adverse reference to prison officers, except for his account of the incident at Whiston, in the letters the inquiry has seen from the period before he went to E wing. At Garth, he is apprehensive about returning to Risley after the alleged assault, but his letters from this period speak mainly of his disappointment in himself, particularly about letting down his children, and his determination to turn his life around. He wants the family to arrange for him to go straight from prison to his sister in Ireland to escape the associations of his life of drugs and crime. However, from later correspondence, once he hears from his girlfriend and knows she has stuck by him, he pins his hopes of a better future on making a home with her.

18.6 Sonny Lodge cannot speak for himself. In connection with many of the events related in this report, the inquiry has to consider how far it can rely on the truth of what Sonny Lodge wrote in his letters or is said to have told others. Second-hand reports of what Sonny said have to be treated with caution. The person who passes on the information may have misunderstood or not remembered accurately a conversation that may not have been important at the time. Or Sonny Lodge may have embellished his stories, to justify his own actions, for bravado or for entertainment. The accounts of what Sonny said to others are mainly not from settings in which there was a solemn obligation for him to tell the whole truth. However, Governor Halliwell believed he was telling the truth about the Whiston incident, with no indication that Sonny was seeking any benefit for himself.

18.7 Several people said Sonny Lodge told them that when he cut his arms in June he was depressed by the death of a child. No one who has given evidence over the years had any knowledge of Sonny having a child who died. It has sometimes been suggested that this casts doubt on Sonny Lodge's credibility; although his sister told the inquest she had heard rumours but did not enquire. She wanted Sonny to pull himself together for the sake of the children she knew and did not want to hear that Sonny might have other children. She said that as a rule he would not say something that was untrue. The day centre manager who knew Sonny Lodge reportedly said in oral evidence to the inquest that Sonny Lodge would hide his troubles when they were clearly abundant and that he dreamed of sorting himself out but was unable to fight his drug problem.

18.8 Dr Wright told the inquiry he thought it likely that the fits Sonny Lodge seemed to experience on occasions in prison were not true epileptic seizures but feigned for some form of secondary gain. Dr Wright declined to draw any broader conclusion about Sonny Lodge's general truthfulness from his conclusion that Sonny might resort, in certain circumstances, to feigning fits.

Did Sonny Lodge's behaviour in prison deserve the attention it attracted from prison staff?

18.9 People who knew Sonny Lodge found the allegations of assault out of character. Sonny Lodge's history of offending included one charge of causing actual bodily harm in 1987 for which he was fined £100. Sonny Lodge's sister said he was not aggressive and she had never known him to pick a fight. The day centre manager said Sonny Lodge thought he was *"one of the big boys but he never was"*. She found him *"a nice lad".* The

surgeon at Whiston Hospital found Sonny Lodge "*calm and cooperative".* The healthcare officer at Garth described his demeanour as *"pleasant and cooperative".* The medical officer at Garth described him as *"a quiet, pleasant individual."* Governor McColm told the Prison Service investigators, *"Everybody else says that this young man was very wilful and I honestly can't see that."*

18.10 Others describe Sonny muttering or mumbling when things went against him and he told Father McCann and Governor McColm about reacting to adversity with a nervous laugh. There are instances of Sonny Lodge being said to be abusive when agitated: to a nurse after he cut his arms at Risley, and in the waiting area at Whiston hospital, as well as entries in the history sheets critical of his attitude to staff. In May 1998 he was banned from Manchester Drug Service for six months for threatening behaviour towards one of the doctors. The diagnosis of dissocial personality disorder by the psychiatrist at Warrington Hospital was only tentative but Dr Wright found it appropriate and said that risk of violence and threatening and abusive behaviour could be characteristic of the disorder.

Was Sonny Lodge victimised by staff because he was alleged to have assaulted a prison officer?

18.11 Sonny's core record, which would have travelled with him to Manchester, contained papers for the adjudication that was opened and adjourned at Garth about the alleged assault on Officer Brownley. After induction, the core record would have been stored in the prison administration centre and not held on the wing. On E wing Sonny Lodge asked Officer Thompson to make enquiries about whether the police would pursue the case. The officer's entry in the history sheets for 17 July referred to the charge for *"alleged assault at Risley on Officer Brownley".*

18.12 Ms Stanway and Father McCann said that Sonny Lodge attributed various conflicts with staff at Manchester to retribution for the alleged assault on Officer Brownley. Indeed Ms Stanway and Father McCann said Sonny told them that certain officers said as much to him.

18.13 Sonny Lodge's dated letters make no adverse comments about prison staff until 18 July – the day after Officer Thompson's entry in the history sheets that Sonny had asked him to enquire about the assault charge. Apparently Sonny Lodge had no inhibition about disclosing the incident to the officer. That might be because he did not

expect staff to treat him badly because of it or because he had reason to believe it was already known to prison staff.

18.14 Prison records and Sonny Lodge's letters indicate that he had a number of run-ins with officers after 18 July. In a letter of 25 July to his sister, he says the officers have been trying to provoke him because of the Whiston incident. On 16 August, in a letter to his girlfriend, he says he knew he would get stitched up as soon as an officer *"gave me loads about that nicking in Risley"*.

18.15 I have found no evidence, apart from Sonny Lodge's own belief, that he was singled out for systematic victimisation at Manchester because of the alleged assault on Officer Brownley. However, from what he reportedly said to people, and from his letters, it seems that on occasion it may have been referred to. There is no guarantee that people will always tell the unvarnished truth in personal letters to their loved ones but it seems unlikely that Sonny Lodge so consistently attributed conflicts with staff to the Whiston incident without there being some foundation. There were opportunities for officers to see reference to the alleged assault when making other entries in the history sheets and it is not inconsistent with what the inquiry has learned about Manchester prison at the time that some officers took it upon themselves to bring prisoners into line in authoritarian fashion.

Factors that affected Sonny Lodge's state of mind

18.16 Sonny Lodge's troubles did not start in prison. He had a poor start in life, a substantial record of petty crime and longstanding dependence on drugs. He had self-harmed before his prison sentence in 1998. He was disappointed in himself, especially in failing to be a good father to his children.

18.17 It is evident from Sonny Lodge's letters that his hopes for a home and future life with his girlfriend, free of crime and drugs, was a critical support, keeping him going. The fact that sanctions in prison, coupled with lack of money to buy phonecards, frequently prevented him telephoning his girlfriend was a cause of distress.

18.18 From his letters, it appears that Sonny Lodge's belief that he was at the mercy of the arbitrary authority of hostile staff caused him additional distress. The mood expressed in his letters veers from determined optimism and, sometimes, defiance, to despair, at times within one letter. Sometimes he says he can cope with the rigours of prison and even a fresh sentence but he cannot bear to see his girlfriend's distress. The

fact that, as he sees it, injustice meted out by some prison officers denies him contact with his girlfriend, but most of all release to go home, and, perhaps, as a result, his relationship and all hope, seems to be what distressed him most acutely.

18.19 Dr Wright was asked whether Sonny Lodge might perceive that he was being victimised without that being either a consequence of mental illness or objectively justified. In other words that the officers might be using their authority appropriately but their actions interpreted by Sonny Lodge as victimising. Dr Wright confirmed that this was possible and commented that once somebody feels victimised there is an "*amplification"* of their emotions such that any small trigger is magnified.

18.20 Dr Wright noted that at the adjudication Mr Lodge presented as "*resigned*". Dr Wright took that to indicate a sense of powerlessness. He concluded that in the final week of Sonny Lodge's life his relationship to those in authority over him was acting against his health. Referring to his sense of injustice about not being released, then being subject to a cell search, then the rules being put on the wall, Dr Wright said it gave a sense of how somebody could feel there was no way they would be able to fight.

Findings

18.21 I find that:

- Some prison officers may have spoken to Sonny Lodge about the incident at Whiston Hospital but I have found no evidence of prison officers conspiring to victimise him because of it.
- Repeated loss of association through the unfair wing-based disciplinary system increased Sonny Lodge's isolation, from support inside the prison and through family contact, and his alienation from prison staff. This may have contributed to deterioration in his behaviour, evoking increasingly authoritarian responses from staff.
- Sonny Lodge's sense of victimisation may have been exaggerated but it was not without foundation. It had a harmful effect on his state of mind.

Chapter 19:

THE SEARCH AND THE INCIDENT IN THE CELL (1): CONSIDERATION OF THE DECISION TO SEARCH THE CELL AND THE CONDUCT OF THE SEARCH

Introduction

19.1 The Inquiry undertook to examine conflicts in the evidence about the reasons for the search, the justification and conduct of it, the incident in the cell and whether these events may have contributed to Sonny Lodge's vulnerability. This chapter considers the justification and conduct of the search. The next chapter considers the incident when Sonny Lodge came back to the cell. Findings relating to both the search and the incident that happened afterwards are in paragraph 20.9.

Consideration

Loss of association

19.2 The wing based disciplinary system that had been criticised by the Prisons Inspectorate was not confined to K wing. In 1998, the Inspectorate commented:

"All the officer had to do was to record in a book the prisoner's name and state why association had been stopped. Although this also required the counter signature of a SO, it was not done in some cases." (HMCIP 1998, paragraph 3.34)

19.3 On G wing on 27 August, Officer Downs decided Sonny Lodge should be locked up for the evening. He said it was not necessary to seek a senior officer's approval as a senior officer (SO) was present when he told Mr Lodge. Officer Downs said that if the SO disagreed he would have said so. He saw no difficulty about the SO seeming to undermine a prison officer's authority in front of a prisoner. There was no record of the punishment in the restriction of facilities record as required. Officer Downs said he intended to complete the record later in the evening. By then the SO would have gone off duty so could not have signed the record as required, that day.

19.4 The incident illustrates the inspectorate's observation about a lack of proper managerial supervision.

Mr Gray's request to stay in during association

19.5 Sonny Lodge's cellmate, Mr Gray, said he asked to stay in the cell during association because he was concerned about Sonny. The inquiry does not know to whom Mr Gray made this request or in what terms, nor indeed can the inquiry be certain

that it was made at all. However, in his interview with the police in 1998 Officer Bowcock thought that 90% of the time officers would refuse such a request. That chimes with what the inquiry has learned about an authoritarian culture at the time. SO Nuttall said that Mr Gray would have been entitled to stay in the cell if he wanted to. Ten years on, Officer Bowcock agreed.

The decision to search Mr Lodge's cell

19.6 The inquiry undertook to examine conflicts in the explanations that were given at various times for selecting Sonny Lodge's cell for searching. The underlying question is whether the decision to search was legitimate or vindictive.

Conflicts in the reasons given for the search

19.7 Officer Downs told the adjudicator on 28 August 1998 that the reason for the search was entries in Sonny Lodge's record. He said the same to the police on 23 September 1998. At the disciplinary investigation in September 1999, Officer Downs did not have a copy of his previous statement. He said Officer Bowcock approached him and said that entries in the observation book made Sonny Lodge a target.

19.8 Officer Bowcock told the adjudicator there were comments in the observation book. He told the police on 23 September 1998 that the main reason was that Sonny Lodge had had a visit. When told there were no adverse entries in the observation book he conceded that he must have been mistaken and that he had been in conversation with Officer Downs. At the disciplinary investigation in September 1999, Officer Bowcock again said he had referred to the observation book. At that point in the interview Officer Bowcock had not been provided with a copy of his previous statement.

19.9 The observation book was important. The entries about Sonny Lodge in the G wing observation book were those from 25 August about Ms A's concern for his safety.

19.10 Officer Bowcock also told the police that he could see from the records that cell G3-24 had not been searched before in the searching cycle. That was not true. Officer Bowcock told the police that when he came to complete the search records the next day the papers had gone. Officer Bowcock confirmed to the inquiry that entries about five searches on the excess search sheet on the day in question were in his handwriting.

Was the decision to search legitimate?

19.11 The inquiry heard evidence about the difference between targeted and routine searching. The inquiry understands the search to have been part of the routine searching regime, which is a necessary part of wing security. All cells on G wing having been searched in the cycle, any cell search that evening would be an 'excess' search.

19.12 Officers Downs and Bowcock told the inquiry that SO Nuttall authorised the search and that they told him whose cell they were going to search. SO Nuttall recalled only that the officers said they were going to do a search.

19.13 The cell or prisoner may or may not have been identified but there is no disagreement that the officers were detailed to search that evening and were trusted with discretion as to which cell to search. But searching is a pinch point in prisons. Prisoners understandably dislike it. It involves strangers rifling through one's personal possessions and includes a strip search, which will always be humiliating no matter how sensitively conducted. Searching is a necessary evil but, in my experience, it is part of prisoner folklore that cell searches can be used punitively, to keep selected prisoners in line. It is part of good management to guard against that happening, or seeming to happen.

19.14 For routine searching, the usual practice is to search both prisoners in a two-man cell. We were told that in 1998 it was not uncommon to search cells when prisoners were not there. The officers decided to search G3-24 because Sonny Lodge had come to their attention and he was conveniently available. Little if any effort was made to locate Mr Gray and his name was not entered on the searching sheet. There is little doubt that the search was personally directed at Sonny Lodge.

19.15 Was there a link between the search and the altercation in the afternoon? There undoubtedly was. The inquiry accepts Officer Downs' evidence that he and Officer Bowcock would probably not have alighted on Sonny Lodge's cell if Officer Downs had not been writing in his record at the time. But was it intended as additional punishment, to teach Sonny Lodge to keep his nose clean, or as a provocation, *"a wind-up"*? Both officers vehemently denied it. Of the altercation between Sonny and Officer Downs in the afternoon, SO Nuttall commented:

"On a scale of 1 to 10 in the prison, that was fairly much a 1…. prisoners do tend to speak the language of the streets and vent their frustrations rather quickly and quite

forcefully, but for prison staff, it's pretty much a day-to-day occurrence. It's not something that lays heavy on you and that you would consider being a major altercation, so I wouldn't believe there would be any lasting effect from the original altercation."

Though Officer Downs decided Sonny Lodge deserved to be locked up for the evening because of it.

19.16 From one point of view, Sonny was an obvious target. According to his history sheets he had been caught swinging lines on K wing. Officer Downs said Sonny's behaviour aroused his suspicions. Unauthorised articles are sometimes passed into the prison on visits. He was on *"bang-up"* already so the officers could do a search without interfering with another prisoner's association period, which no doubt would have been resented.

19.17 From Sonny Lodge's point of view, the search seems to have heightened his sense of victimisation. He believed the officers were going to plant something in his cell. He was wrong about that. Nothing was found in the search and there has been no evidence of any foundation for that particular belief. However, there were aspects of the search that give the impression of a connection with the incident in the afternoon. Officer Downs' involvement was one link. Then, without any apparent cause, Officer Bowcock took the opportunity to remind Sonny Lodge not to abuse the officers. That could only have been because of what Officer Downs told him about happened in the afternoon.

Entries in the history sheets

19.18 The four pages of history sheets contained three significant entries apart from the disciplinary ones. They stated that Sonny Lodge was alleged to have assaulted Officer Brownley at Risley, that he had been on F2052SH after serious self-harm, and that he had been to a discharge board that day but was not for release.

19.19 Did the officers see the entry about the alleged assault and were they influenced by it? Officer Bowcock says he did not look at the history sheets at all though he had formed an impression that Sonny Lodge was not a model prisoner. Officer Downs wrote in the history sheets and saw other entries but said he did not recall seeing the reference to the alleged assault. Both officers said they were certainly not influenced by it. Father McCann said Sonny Lodge told him that during the incident in the cell one of the officers referred to the alleged assault and called Officer Brownley by his name. That is not sufficient evidence to find that it happened.

19.20 Did the officers know that Sonny Lodge had been on F2052SH? Both said they did not see the entry about this in the history sheets or notice the scars on his arms that had been obvious to his legal representative and Officer Sanderson the same week.

19.21 Did the officers know that Sonny Lodge was due to be released but would be held in prison on another charge? Officer Downs had made the entry about the discharge board but there was no evidence that the officers knew the circumstances or that Sonny Lodge was in a heightened emotional state because of it.

Was the cell left in a mess?

19.22 Like selection for searching, the condition of a cell after a search is a pinch point, an opportunity for punishment by stealth. Officers Downs and Bowcock said they did not remake the bed but that they tried to leave the cell much as they found it. Sonny Lodge said that when he returned to the cell his "*property was everywhere"*. Peter Gray said property and bedding was upside down and pictures and some mail had been ripped up, but there is evidence that two pictures were returned to Mr Lodge's family in good condition.

Chapter 20:

THE SEARCH AND THE INCIDENT IN THE CELL (2): FURTHER CONSIDERATION AND FINDINGS

Introduction

20.1 This chapter considers the evidence about the incident in cell G3-24 after the search and states the inquiry findings about both the search and the incident in the cell.

Consideration

The ringing of the rules in red

20.2 At the adjudication, Officer Bowcock reported that he began to explain the G wing rules and regulations to Sonny Lodge, who became angry and lunged at him. Sonny Lodge told the governor that when he came back to the cell his property was everywhere, he laughed nervously, the officer lunged at him and he curled up in a ball on the floor.

20.3 Sonny's cellmate, Mr Gray, told the Prison Service investigation about finding the rules ringed in red on the cell noticeboard. The police asked Officer Bowcock about it. Officer Bowcock told the police that he reminded Sonny Lodge of the rules because he had formed the impression Sonny Lodge was not a model prisoner. To the inquiry, Officer Bowcock acknowledged with hindsight that the way he drew Sonny Lodge's attention to the rules may not have been good practice. It is to Officer Bowcock's credit that he now recognises that. His action was misguided. It was demeaning to Sonny Lodge and, coupled with Officer Downs' involvement in the search, it would have indicated a clear link between the search and the altercation in the afternoon, suggesting that the search was additional punishment.

Evidence about the alleged attempted assault

20.4 Officer Bowcock said that Sonny Lodge moved forward with arms raised and, believing he intended to assault him, Officer Bowcock took pre-emptive action, pushing Mr Lodge into the corner of the cell and grabbing his arm. Sonny Lodge said he did not threaten the officer but the officer lunged at him. Officer Downs and Bowcock then restrained Sonny Lodge. They said that he resisted. Sonny Lodge said he curled up on the floor.

20.5 Mr Gray and Mr Davies, who were prisoners on G wing and friends of Sonny Lodge, gave evidence that they saw an officer assault Sonny Lodge. The inquiry was unable to trace Mr Gray and Mr Davies so could not probe their evidence. In weighing the evidence of Mr Gray and Mr Davies I take note of the following points:

- From the positions where they said they were standing at the time, they would have been able to see into cell G3.24 to some degree, depending how far the door was open.
- The fact that Mr Gray, and Mr Davies, following him, named officers who were not on the wing that evening does not wholly undermine their evidence. It is likely that they were mistaken about the officers' names.
- Mr Gray says that there were three officers in the cell with Sonny at the back of the cell when he saw the officer whom he called Mr Collier strike Sonny Lodge with his left arm.
- Mr Davies described two officers in the cell both moving towards the door. He says Sonny was in the middle of the cell. The officers were leaving when the one behind, Mr Collier, turned back and punched Sonny with a clenched right fist.

20.6 Mr Davies and Mr Gray had no opportunity to confer with Sonny Lodge about what happened in the cell. It seems likely they saw something of what happened. But their evidence may relate to the control and restraint not the initial flashpoint. There are discrepancies in their accounts and their interpretation of events may have been tinged with prejudice. It is not sufficient to refute the evidence of the two officers that they laid hands on Sonny Lodge only in the course of control and restraint.

20.7 The critical questions are whether the officers' use of force was prompted by an attempted assault by Sonny Lodge; whether it was necessary; and whether it was no more than required. The evidence of Mr Gray and Mr Davies does not settle that. The charge against Sonny Lodge was attempted assault not assault. Attempted assault relies in large measure on the alleged victim's interpretation of the alleged perpetrator's intent. At this distance in time and in the absence of evidence from Sonny Lodge himself, the inquiry cannot say whether the gestures of Officer Bowcock or Sonny Lodge were the more threatening.

20.8 In drawing conclusions about the incidents involving Officer Downs, the inquiry has not attached specific importance to the judgment in the case of Mr Howarth.

However, like the various reports of the prisons inspectorate that the inquiry has referred to, the judgement indicates the manner in which some prison officers apparently found it acceptable to relate to prisoners in Manchester at the time.

Findings

20.9 I find that:

- The loss of association imposed by Officer Downs was not properly authorised and was not recorded in the restriction of facilities record as required.
- Sonny Lodge was the principal target of the search but there is no evidence to show that his cellmate was deliberately excluded from the cell or from the search for any malicious motive.
- It was legitimate to search cells more than once in a searching cycle and Officers Bowcock and Downs had authority to select Sonny Lodge's cell for an excess search that evening.
- There were entries in Sonny Lodge's record suggesting that he had previously handled unauthorised articles. Setting aside the rough justice of the wing-based disciplinary system, this gave some grounds for selecting him for a search.
- I attach no weight to the discrepancy between the searching officers and the senior officer about whether they identified the prisoner and cell they intended to search, but searches can be used punitively and legitimate searches can give rise to the appearance of unfair treatment. Wing managers should exercise active supervision over the selection of cells for searching.
- When asked to justify the search at the adjudication and to the police, and when explaining why he did not complete the record, Officer Bowcock showed a casual disregard for his obligation to give evidence with care and accurately.
- I do not find that the search was a consciously vindictive act by the officers but, in taking note only of the negative entries in his history sheets, and in failing to notice the scars on his arms, they showed indifference to how Sonny Lodge might view the search as an additional sanction and indifference to his welfare.
- The way that Officer Bowcock drew Sonny Lodge's attention to the rules was provocative and unprofessional.

- There is insufficient evidence to conclude whether the gestures of Officer Bowcock or Sonny Lodge were the more threatening.
- There is insufficient evidence to determine whether the use of force on Sonny Lodge was justified and lawful.
- An adjudication about a related charge against a prisoner is not a sufficient investigation of the use of force. Prison managers should have ensured that use of force records were completed and, as a matter of routine, that an incident involving use of force was investigated.

Chapter 21:

THE ADJUDICATION AND PUNISHMENT

Introduction

21.1 The inquiry undertook to examine whether the conduct and conclusion of the adjudication was in accordance with Prison Service guidance. This chapter considers the conduct of the adjudication and the supervision of Sonny Lodge in the segregation unit. It also refers to the assessment of fitness for adjudication and cellular confinement but that has been considered more extensively in Chapter 13.

Administrative background

The Prison Discipline Manual

21.2 The Prison Discipline Manual contains instructions and guidance on the discipline system. The 1995 edition of the manual (PDM 1995) was in use in 1998. Among other things, the manual said that:

- The adjudicator must come to the adjudication afresh with an uncluttered mind (this is called the *de novo* principle) and without bias which might arise from prior knowledge or personal interest. The manual says that a general good knowledge of the prisoner's history would not be sufficient to amount to bias. The adjudicator must determine the case solely on the evidence presented at the hearing and the proceedings should be started without access to the prison record of the prisoner accused or record of any previous disciplinary offences in prison (PDM 1995, paragraphs 3.12-3.13, 9.10-9.11, 10.1, 10.2 and Appendix 4 paragraph 5 and 20).
- If an allegation is made by the accused against staff that is relevant to the charge, the adjudicator should consider what steps need to be taken to allow a full investigation. The manual says that it will often be the case that the adjudicator can thoroughly investigate the allegation at the adjudication by calling witnesses and questioning the prisoner making the allegation. In these cases, the adjudication may be concluded without a separate investigation (PDM 1995, paragraphs 5.18-5.19).
- On the day of an adjudication hearing and before the hearing starts the accused will be examined by a medical officer who will note on form F256 (the record of

hearing) whether the prisoner is in a fit state of health to attend the hearing and, if necessary, to undergo a punishment of cellular confinement (PDM 1995, paragraph 2.15).

- The final decision as to whether an accused is fit to face the hearing rests with the adjudicator (PDM 1995, paragraph 2.17).
- Prisoners serving a punishment of cellular confinement will be observed by an officer at least once an hour and will be visited daily by the chaplain. The 1995 manual states that the medical officer will visit daily to assess the physical, emotional and mental well-being of the prisoner and will note on the prisoner's medical record whether or not s/he remains fit to continue undergoing the punishment (PDM 1995, paragraph 7.24).
- An accused may be guilty of an assault if, without applying unlawful force, s/he intentionally or recklessly causes another person to fear the application of immediate unlawful force (PDM 1995, paragraphs 6.4 and 6.5). The test for an attempted offence is that the accused did an act which was more than merely preparatory to the commission of the intended offence and intended to commit the full offence (PDM 1995, paragraph 6.74).
- Charges under the Prison Rules must be proved beyond reasonable doubt (PDM 1995, paragraph 7.1).
- The adjudicator must ensure that a record of proceedings is taken down on form F256, which may be required for a formal review of the hearing. It need not be a verbatim transcript but it must record the essence of the case and indicate how the adjudicator pursued the inquiry. If the person is found guilty it should be clear from the record why the adjudicator rejected any defence put forward (PDM 1995, paragraph 4.23).

Changes to the system for adjudications since 1998

21.3 Since 1998 the jurisdiction of governors to determine offences under the Prison Rules has been reduced, following the case of *Ezeh and Connors v UK* (European Court of Human Rights; 2003 Application Nos. 39665/98 and 40086/98). The Court found that the applicants' right to a fair trial under Article 6 of the European Convention was breached in adjudications in which governors imposed added days in prison of 40 and 7 days respectively.

21.4 PSO 2000, which came into effect in January 2006, has replaced the Prison Discipline Manual. In any case in which the adjudicating governor considers that a charge if proved could warrant punishments of additional days in prison they must adjourn the hearing and refer the case to an Independent Adjudicator appointed by the Lord Chancellor.

Changes to assessing fitness for adjudication and cellular confinement

21.5 There have also been changes to the system of assessing fitness. These are described above in paragraphs 13.10 to 13.16.

Consideration

21.6 It was clear to the inquiry that, even though many years have now passed, Governor McColm is still painfully aware that it was his decision to place Sonny Lodge in segregation. He has not sought to minimise his involvement and it was evident from his oral evidence that he has searched memory and conscience to consider whether he might have acted differently. In his opening statement to the inquiry, Counsel for the family said*: "From the written evidence, it seems clear that Governor McColm had Sonny's best interests in mind and was concerned about allowing him to return to the normal wing…."* I agree. In relating how he made his decision to impose cellular confinement rather than another punishment, Governor McColm has repeatedly said that Sonny Lodge's well-being was at the forefront of his mind. I recognise that Governor McColm was motivated by his judgment of where Sonny Lodge would obtain the best care. However cellular confinement is a punishment and the Prison Service now recognises that isolation increases vulnerability. I welcome the additional risk assessments that are now required before cellular confinement is imposed at adjudication.

The investigation of the charge against Sonny Lodge

21.7 Representations have been made that I should consider the adjudication in the context of the approach and standards at the time. I have been reminded that the F256 record of hearing does not claim to be verbatim and that it was unusual for an adjudication to last as long as 20 minutes. I have been told that the length of time and the volume of paperwork generated are unusual, even by today's standards and that this underlines the level of consideration that Governor McColm gave to the case. I recognise that Governor McColm was an experienced governor who approached the

hearing conscientiously but my conclusions about the investigation of the charge are based on what I consider to be acceptable standards of justice, not on practice in the Prison Service at the time.

The *de novo* principle and bias

21.8 It is arguable that Governor McColm did not come to adjudication without prior knowledge. Governor Munns had passed on to him the information that Sonny Lodge was likely to make a counter-allegation that Officer Bowcock had attempted to assault him as payback for some old grievance. I do not think that this knowledge disqualified Governor McColm from considering the charge against Sonny Lodge with an open mind.

Sonny's allegation against Officer Bowcock

21.9 Adjudicators were advised to consider whether an allegation against a member of staff could be fully investigated within the adjudication hearing. Governor McColm concluded that Sonny Lodge's allegation that the Officer lunged at him could be.

21.10 Having made that decision, he was required to ensure that the allegation was fully explored. Sonny Lodge had not had the benefit of any advice about what constitutes attempted assault. He was at a disadvantage as the defendant facing a charge, compared with his position if he had been interviewed as a complainant.

21.11 Governor McColm assumed that it was a case of Sonny Lodge's word against that of the officers but, from the record, it appears that the officers' evidence was less than detailed. According to the governor's notes, it was largely confirmation of leading questions by the adjudicator.

21.12 From his own evidence, it was questionable whether Officer Downs was in a position to see what happened as he was occupied with the lock. The governor did not probe the context of the search to see whether there might be any anomaly about it that might cast doubt on the officers' good faith. Officer Downs and Officer Bowcock gave different reasons for it, one referring to entries in Sonny Lodge's record and the other saying there were entries in the observation book. The governor did not ask for use of force statements. It is said that they were formulaic and uninformative at the time but have now been improved. He did not contemplate the possibility of there being other witnesses to what happened in the cell.

Beyond reasonable doubt

21.13 In order to find the charge against Sonny Lodge proved, the adjudicator had to be satisfied beyond reasonable doubt. For the same reasons that the inquiry considers that Governor McColm made insufficient investigation to dispose of the allegation against the officer, the inquiry concludes that he did not probe the evidence sufficiently to justify a finding that the charge against Sonny Lodge was proved.

Fitness for adjudication and cellular confinement

21.14 The prison medical officer saw Sonny Lodge before the adjudication and, on the basis of a conversation, but without reference to his medical history, found him fit for adjudication and cellular confinement. When he decided to impose cellular confinement, Governor McColm had no knowledge of Sonny Lodge's previous self-harm or the concerns his girlfriend expressed that week. Dr Wright has commented on the system for assessing prisoners' fitness and the issue has been considered in Chapter 13. Suffice it to say here, that an assessment for cellular confinement without access to any history seems manifestly inadequate. That has been recognised in the system now in operation.

21.15 Policy at the time of Sonny Lodge's death required prisoners in segregation to be observed at least once an hour. Mr Johnson left Sonny Lodge sometime between three and four o'clock. Sonny Lodge was seen during roll check at about 4.40 pm. No one came to his cell again until 6.20 pm.

Findings and recommendation

21.16 Findings:

- Governor McColm acted in good faith. He had no knowledge of Sonny Lodge's history of self-harm or the concerns expressed by his girlfriend that week.
- Governor McColm's decision to segregate Sonny Lodge was based on an evaluation of where he would receive the best care, but cellular confinement is punishment and isolation may increase vulnerability.
- Governor McColm did not explore the circumstances of the incident sufficiently to dispose of Sonny Lodge's counter-allegation against Officer Bowcock.
- Governor McColm did not explore the circumstances of the incident sufficiently to find that the charge against Sonny Lodge was proved beyond reasonable doubt.
- The assessment of Sonny Lodge's fitness for adjudication and cellular confinement before the hearing complied with Prison Service policy at the time

but the system of assessing fitness without regard to any history or prior knowledge was not satisfactory. Current Prison Service policy now requires a risk assessment, including reference to medical records, before a punishment of cellular confinement is imposed.

- After 4.40 in the afternoon on 28 August, when Sonny Lodge was in segregation, he was not observed at least once an hour as required by the Prison Discipline Manual.

21.17 Recommendation

- that the Prison Service advises adjudicators to consider examining use of force statements in any adjudication where force has been used following an incident of alleged assault.

Chapter 22:

COMMUNICATIONS AND RECORD-KEEPING

Introduction

22.1 The inquiry undertook to examine deficiencies in communications and record-keeping and what role, if any, this played in the circumstances of Sonny Lodge's death. This chapter examines instances of records that were not completed as required by procedures at the time and describes some changes in practice. It briefly considers the significance of recording and sharing information about risk of suicide and self-harm but that is considered more fully in Chapter 15.

Consideration

22.2 A healthy prison thrives on positive interaction between people: staff and staff and staff and prisoners. Events happen quickly. Prison staff have to react quickly. An investigator should be cautious about imposing a bureaucratic standard where written records assume undue importance at the expense of human relationships. But in an environment where staff exercise coercive powers that would be unlawful in another setting certain records are necessary for accountability and good management.

Use of force and injury to inmate

22.3 The Prison Service confirmed that Use of Force statements were a requirement in 1998 and that officers were trained to complete them. Force was used on Sonny Lodge at Whiston Hospital and in cell G3-24. On neither occasion were Use of Force statements completed.

22.4 On both occasions Sonny Lodge was seen to have visible injuries after the event. No F213 Injury to Inmate forms were completed. The Prison Service says that if there was a mark on Mr Lodge an enquiry should have been made by staff into the nature and circumstances of how it was caused and appropriate paperwork raised if it was deemed an injury.

22.5 After the Whiston incident, the bruise to the side of Sonny Lodge's neck was recorded fully in the Inmate Medical Record but that was a confidential document that would not have come been available to prison managers.

22.6 After the G wing incident, Nurse Paterson said that Sonny Lodge told her he was fine and not hurt and that a mark she noticed on his forehead seemed to be an old

graze. As Sonny Lodge had just been forcibly restrained it would have been good practice to record the mark and his explanation for it. At the adjudication next day Sonny Lodge said that he sustained *"the bump on his head"* during the incident.

22.7 Use of Force is unlawful unless it can be shown to be justified. On every occasion that it is used it should not only be recorded but investigated. Similarly, unexplained injuries should be recorded and investigated promptly for forensic and clinical reasons. This protects prisoners and staff and provides essential management information.

22.8 Completing forms does not guarantee useful content. Officers at Risley and also at Manchester said that in 1998 it was customary for senior staff to prepare paperwork for officers to sign. Other witnesses commented that Use of Force statements at the time were generally formulaic, stating little more than the fact of the restraint and that it was in accordance with approved techniques.

Current practice

22.9 Prison Service Order 1600 on use of force now requires staff involved in restraining a prisoner to make a full statement of the circumstances including any prior briefing, what led to use of force, instructions given to the prisoner, their perception of the prisoner's behaviour, how they tried to de-escalate the situation, and other matters, about the particular incident.

22.10 Completion of forms does not guarantee they will be reviewed, acted upon and any lessons learned. In respect of unexplained or non-accidental injuries to prisoners, Governor Vince told us that Manchester has recently issued a revised form to be used for all prisoners who are discovered to have an unexplained or non-accidental injury. As well as completing an F213 and giving priority to medical assessment, sections within the form provide for a statement by the prisoner, a summary report and investigation and findings and recommendations by a responsible manager to prevent recurrence. The Safer Custody Manager keeps a log of all F213s.

Events on G wing on 27 August

22.11 The loss of association records were not completed by Officer Downs on 27 August. Officer Downs explained this as an oversight because of the incident after the search. However, the loss of association record ought to have been completed with the authorising senior officer's signature, not left to be filled out by the officer at some later

opportunity when the senior officer was no longer on duty. The prisons inspectorate had criticised a lack of managerial supervision of the scheme that allowed prison officers to punish prisoners through loss of association.

22.12 Neither Officer Bowcock nor Officer Downs completed the search records after the incident on 27 August. Officer Bowcock told the police that this was because the papers were no longer available next day, yet he confirmed to the inquiry that he wrote the entries about five searches that he conducted with another officer on the day in question.

Communicating information about prisoners

22.13 By virtue of their imprisonment, prisoners are in many ways denied capacity to take responsibility for themselves. Their access to movement, family, friends, goods and services, is controlled by prison staff. This creates obligations that must be met by prison staff and managers. Recording information and sharing it efficiently is key to high quality care for prisoners. It is also necessary – and practised – for the security of the prison. The Prison Service has developed highly effective information systems for managing security information.

22.14 There were deficiencies in recording and communicating significant information about Sonny Lodge. Some information that was recorded was not taken into account. In particular:

- Despite the note about his F2052SH and that he should be monitored carefully and return to E wing after the week on punishment, Sonny Lodge was moved to K wing on 1 August not E wing with no reason recorded. The previous entry was either not read or countermanded without explanation.
- The healthcare officer who saw Sonny Lodge in reception on 25 August did not see Sonny Lodge's records and did not know he had a history of self-harm. Yet the escort records gave this information.
- There was an entry in the Inmate Medical Record about Ms A's telephone call on Tuesday 25 August. The next entry was added on Thursday 27 when Mr Lodge was on his way to segregation. It was either not read or prompted no concern.

- There was an entry in the G wing observation book for 25 August about Ms A's telephone call. No one followed it up to see whether Sonny Lodge was still feeling all right.
- SO Nuttall did not read the observation book when coming on duty but relied on the outgoing senior officer to tell him anything of note.
- There was no entry in Sonny Lodge's history sheets about Ms A's concern so once he left the wing the staff on his new unit had no record of it.
- The chaplain who visited Sonny Lodge on Wednesday did not share her concern for Sonny with wing staff and did not record the nature of Ms A's concern; there was no plan for the chaplains to continue to support Sonny Lodge after Thursday morning.

22.15 In a large prison with a changing population, care for prisoners means that consistent use of records is a crucial proxy for consistent relationships. Protecting prisoners from suicide and self-harm cannot rely on one-off judgments made in isolation. It is a process. Judgments may need revising in response to changing circumstances or new information.

22.16 The Prison Service says there is no overarching prison policy document about record-keeping and communications but within each policy there are relevant requirements, for example, the completion of Use of Force Forms and in ACCT.

Findings and recommendation

22.17 I find that:

- Use of Force and Injury to Inmate forms should have been completed on two occasions and were not.
- On 27 August 1998, loss of association and search records were not completed in accordance with the required procedures.

22.18 I repeat in part the finding in Chapter 15

- Information was not always recorded so that it was available to others. Where information was available in the IMR, the escort records, the observation book and the history sheets it was either not referred to when, reasonably, it should have been, or it was not taken into account, when, reasonably it ought to have

prompted special protection. Consequently, judgments were made not to open an F2052SH in ignorance of material facts that ought to have been known.

22.19 I recommend that:

- the Prison Service considers whether specific guidance might usefully be issued on the appropriate use of prisoners' history sheets, in particular so that:
  - information affecting a prisoner's custody and care is reliably recorded in his or her personal record; and
  - it is referred to when prisoners change locations or other significant events occur;
- the Prison Service considers issuing specific advice about recording information received from family, friends or outside agencies that a prisoner may be at risk of suicide or self-harm.

Chapter 23:

WHAT HAS CHANGED AT MANCHESTER PRISON

Introduction

23.1 The Inquiry undertook to examine how the care of prisoners at risk of suicide and/or self-harm has changed at Manchester prison since Sonny Lodge's death.

23.2 The inquiry was asked to identify any deficiencies in the care afforded to Mr Lodge by the Prison Service that may have had an influence on his death *and to help prevent such tragedies in future.* It would not have served the second part of the inquiry's remit simply to examine Sonny Lodge's care in the context of policies a decade ago without regard to what the Prison Service has learned since then and the new policies that now apply. The inquiry therefore obtained evidence about changes to the relevant policies and practices since 1998, in the Prison Service generally and specifically at Manchester prison.

Evidence to the inquest

23.3 A former governing Governor of Manchester prison gave oral evidence at the inquest in July 2001 about changes to the prison in response to the Prison Service investigation into the circumstances of Sonny Lodge's death. The Treasury Solicitor's summary states that, among other things, the Governor gave evidence that:

- the wing-based disciplinary system had been abolished
- all staff had been trained in suicide prevention procedures
- adjudicating governors were to be informed of any recent history of a prisoner being subject to F2052SH procedures
- it was established policy not to hold such prisoners in the Segregation Unit except in carefully considered exceptional cases
- a full-time Suicide Prevention Coordinator had been appointed to audit current practice and to initiate development of more effective practices across the prison
- all major wings had televisions in cells.

Manchester prison now

23.4 In evidence to the inquiry, the present governing Governor, Mr Richard Vince, described the policies and procedures at Manchester in a number of areas of prison life and the structures in place to put the policies into practice, to monitor compliance and to train and support staff. This included evidence of the establishment's progress in implementing recommendations made from time to time by the Prisons and Probation Ombudsman and HM Chief Inspector of Prisons (HMCIP).

The Incentives and Earned Privileges (IEP) Scheme

23.5 Reference has been made in Chapter 7 above to the practice of prison staff denying prisoners association for minor infringements. HMCIP had called it "*an arbitrary system with no right of appeal."* Authority for officers to order loss of association was withdrawn in a memorandum dated 1 October 1999 which drew wing managers' attention to the Incentives and Earned Privileges (IEP) system, through which unacceptable behaviour should be addressed (see above, paragraphs 7.11 and 7.12).

23.6 The IEP Scheme governs the extent of privileges (including association periods) that prisoners are permitted over and above the minimum required by the statutory Prison Rules. The Prison Service says that due process and fairness are built into the IEP system in a number of ways. The national policy document on IEP is PSO 4000. It states that decisions about the appropriate privilege level for each prisoner must be open, fair and consistent. The procedures and the findings must be recorded and involve at least two members of staff. Views must be sought from across the establishment, including education and workshop staff, reports from any relevant treatment programmes and personal officers. The decision must be endorsed by a manager at no less than Senior Officer grade. The Prison Service comments that these measures mean that it would be very difficult for a member of staff to use the IEP scheme as a way to intimidate or bully prisoners.

23.7 Manchester's local IEP policy follows the national requirements. A prisoner's incentive level is determined by a review board comprising a minimum of a Principal Officer, Senior Officer, and Personal/Group Officer. Comments from other key workers may be taken by telephone or e-mail if they are unable to attend. All comments should be noted by the board in writing. Prisoners are to be invited to attend and should be able to make oral or written representations.

23.8 PSO 4000 requires management monitoring of the operation of the IEP scheme. A member of the Senior Management Team must carry out monthly checks of a sample of review decisions to ensure fairness and consistency and provide advice and guidance on report writing and decision making as necessary. Figures relating to the scheme must be produced annually for the Senior Management Team and Race Equality Action Team.

Monitoring prison performance

23.9 Mr Vince gave evidence to the inquiry about ways in which Manchester Prison and its staff are held to account and arrangements in place to promote fair treatment of prisoners.

23.10 Manchester Prison operates under a Service Level Agreement. A compliance monitor, who is independent of the prison, reports on the prison's performance to the Prison Service Contracts and Competitions Unit. Periodic inspection by the national Standards Audit Unit rates compliance with Prison Service Standards and the prison also conducts self-audits. Impact assessments, including prisoner consultation and evaluation by the prison's Diversity Team, are conducted on all new policies and procedures.

23.11 Mr Vince described the various ways in which prisoners can communicate concerns. These included: confidential letter to the Governor, the Chair of the Independent Monitoring Board, the Area Manager or a solicitor; telling a member of staff; contacting the Prisoners' Helpline; through regular focus groups; speaking with a Listener or Insider (both are prisoners' peer support schemes); putting a note in the mail box. Complaints may be made through the internal complaints procedure and to the Independent Monitoring Board and the Prisons and Probation Ombudsman. Prisoners are made aware of these channels during induction, and all received a comprehensive induction information booklet.

23.12 The prison takes part in the research measuring the quality of prison life (the MQPL Survey – see paragraph 17.15 above). A survey of prisoners takes place over four days every two years. The aim is to make comparisons between similar prisons to identify examples of good practice and to improve prisons generally.

Safety

23.13 I have described in paragraphs 14.10 to 14.37 above:

- the new national ACCT system for safeguarding prisoners against suicide and self-harm

including, in particular, at Manchester

- the Friends and Family Helpline;
- the procedure followed where individuals or agencies from outside the prison express concern about a prisoner, and
- questionnaires to prisoners after an ACCT plan is closed.

23.14 Governor Vince contrasted the priority now given to safety in prisons with the resources that would have been allocated to it in 1998. The suicide awareness leader in 1998 was a senior officer. There is now a senior management post of Head of Safer Custody and Decency, and a safer prisons co-ordinator, with a deputy to ensure continuity, and a safer custody administrative officer. In November 2008 the prison appointed a Violence Reduction Coordinator. Use of force is reviewed monthly by the senior management team.

23.15 Violence reduction surveys are held twice yearly with confidential questionnaires to all prisoners. The results are analysed to inform the Violence Reduction Strategy of potential areas of distress for individuals. A monthly analysis of anti-social behaviour/violence/assaults is conducted to identify problem areas and provide effective remedies. In addition, the Violence Reduction Strategy draws on managing violence, anti-bullying and cell sharing risk assessment processes and the lessons of independent inquiries, investigations and inspection reports.

The group officer scheme

23.16 Successive HMCIP reports urged the prison to set up an effective personal officer scheme, so that each prisoner has a main and familiar point of contact among prison staff. Manchester has 20,000 to 25,000 movements of prisoners through reception every year. It is obviously more difficult to run an effective personal officer scheme in a local prison like Manchester than in a prison with a settled population of sentenced prisoners. Schemes have to accommodate the constantly changing population of prisoners as well as taking account of staff shift patterns, which may

include long working days followed by several days off. Providing a consistent personal officer service that builds constructive relationships with individual prisoners presents challenges.

23.17 In 2007 HMCIP found that there was a notice on each cell door stating which member of staff had been allocated responsibility for group officer work for the cell occupant. The work of the group officers was monitored monthly. The group officer programme was known to prisoners. They expressed a range of views about whether they would approach the member of staff concerned with personal problems.

23.18 The Governor told the inquiry that the Group Officer Scheme had recently been relaunched. The statement of purpose says:

"The work of group officers is central to the care of prisoners and the security of the establishment. A group officer scheme or shared working arrangement is required to be in operation at HMP Manchester so that particular staff can get to know particular prisoners and prisoners can turn to them for advice and assistance.

"Such continuity can provide and build a personal relationship with the prisoners…."

23.19 Group officers are allocated to particular cells and required to take responsibility for the occupants of that cell. There is a lead officer and a stand-in for each cell. They are required to introduce themselves and interview the prisoner at the earliest opportunity and within one week as a maximum. Instructions to staff say:

"As a group officer you will be the first point of contact for the prisoner within the whole prison system. Group officer relationships with prisoners are critical. You should make each prisoner aware of who the next point of contact is should you be unavailable. You should influence and encourage all prisoners by your example, your standards and your guidance. You are responsible for dealing with documentation relating to your prisoners, helping them resolve problems, setting them targets and giving advice in relation to the IEP scheme and helping them address their offending behaviour.

"As a group officer you should aim to know more about the prisoner than anyone else in the prison, his past history, his risk factors, his problem areas, his achievements and domestic situation, his aspirations and his plans and goals."

The local IEP policy says that personal/group officers must make a minimum of one *"quality entry"* in a prisoner's history sheer each week with *"comments on general*

behaviour, achievements, interaction with staff and prisoners, cleanliness, disciplinary awards, compliance with sentence planning targets and any other relevant information".

23.20 The policy statement emphasises that the scheme improves care for prisoners but also improves staff safety and promotes a safer prison.

Communications and record-keeping

23.21 I have described in paragraphs 22.9 and 22.10:

- the requirements in national policy and at Manchester for recording use of force and injuries to prisoners and for management and monitoring of incidents.

Governor Vince told the inquiry that: reports on use of force require staff to make a full statement of the circumstances, including how they tried to de-escalate the situation; that prisoners are asked to make a statement about non-accidental injuries; and that Injury to Inmate forms are reviewed by a responsible manager and logged by the Safer Custody Manager.

23.22 The inquiry was told that every new entry prison officer at Manchester receives training on the importance of keeping clear and accurate records. This is reflected in annual performance reports and on team meeting agendas. Individuals whose performance falls below the required standard should have this recorded on staff performance and development reports for improvement. Record-keeping also features in management checks and audit.

Healthcare

23.23 I have described earlier in the report

- Healthcare arrangements in the segregation unit at Manchester where there is a dedicated mental health nurse (see above, paragraphs 13.18-13.21).
- Electronic medical records which can be accessed by authorised staff from terminals though not yet in the segregation unit (see above, paragraph 13.22).

Issues raised by the Samaritans

23.24 The Manchester Samaritans and the Safer Prisons Coordinator described a thriving Listeners scheme but some logistical difficulties (see above, paragraphs 14.38 to14.42).

23.25 Ms Crabbe and Mr Dugdale referred to the difficulties of maintaining a full complement of Listeners throughout the prison. It can take from six to 12 weeks to vet Samaritan volunteers to work inside the prison. This reduces the number of Samaritans available to train Listeners which, in turn, tends to reduce the number of Listeners available in the prison.

23.26 Listeners are not always available on all wings. Ms Crabbe commented that it can be difficult to transfer a Listener especially at night.

23.27 There is a lack of privacy in shared cells to use the Samaritans telephones. I have also commented on the difficulty of conducting sensitive conversations in unsuitable locations (see above, paragraph 15.12).

Consideration

23.28 Having listened to Mr Vince's evidence about progress at Manchester prison, one of Mr Lodge's sisters interjected – with vehemence – to say that there were still men dying in Manchester prison. That is true. Since 1998, there have been apparently self-inflicted deaths at Manchester each year to the end of July 2009 as follows:

Table 4

Year	Number of apparently self-inflicted deaths
1999	8
2000	1
2001	1
2002	1
2003	2
2004	6
2005	1
2006	4
2007	1
2008	2
2009	2

23.29 In England and Wales as a whole in 2008, 63 prisoners apparently took their own lives. That is more than one prisoner every week. Every suicide is a grievous loss, for the person who dies and for those close to them. There are many causes for distress in

prison. Many prisoners carry a host of deep-seated problems from their lives outside. A self-inflicted death in prison does not mean that someone in the prison has to be to blame. It is also true that prison staff, especially on the landings, save lives, sometimes through emergency intervention against a determined attempt, uncountable times through small acts of consideration. Not all suicides can be prevented but isolation and inactivity in prison can make vulnerable people despair.

23.30 It is an aspect of this inquiry that through Sonny Lodge's letters, from his family and the evidence of people that he talked to, we have seen something of what it felt like for a troubled young man to be a prisoner in Manchester in 1998, how the face he put on for people he did not know or trust did not tell the whole story, how he responded differently to people according to how they treated him, and how casual mistreatment – by systems or people – causes distress and can engender despair. This report is not social research or management audit. It examines events in an individual life. But recounting the personal experience of Sonny Lodge shows – as many have said before – that the basis of decent prisons is the principle that prisoners are complex individuals who deserve to be treated with humanity and respect.

23.31 In oral evidence to the inquiry, Mr Vince said that he believed that the significant change between 1998 and 2008 at Manchester prison was that suicide and self-harm prevention had developed to become an ingrained part of what prison officers do. This injected *"the qualitative element"*. I repeat Governor Vince's insight that staff could:

"complete the paperwork but if they don't actually care what they're doing and if they're not actually treating people as individuals and looking after them then the paperwork means nought".

23.32 .The Governor has provided evidence of substantial advances in arrangements for the care and assessment of prisoners' well-being and seemingly a change for the better in the ethos of Manchester prison. He also drew the inquiry's attention to some of the structures and systems by which the prison and its staff are held to account, through audit, inspection, and routine management review. Those checks are important. Opportunities for prisoners to raise individual grievances are important too, but they are not sufficient. I welcomed Governor Vince's account of the ways the prison consults prisoners collectively.

23.33 I list below significant changes in arrangements at HMP Manchester that relate to specific problems in 1998 that have been identified in this report. In some cases Manchester's arrangements reflect a national policy; in others a local initiative. It is outside the scope of the inquiry to evaluate how far current *practice* at Manchester prison achieves its aims. That is for those who are responsible for managing and monitoring the prison.

Findings

23.34 From evidence given to the inquiry, I note the following significant changes in arrangements at Manchester relating to specific problems identified in this report:

- In accordance with Prison Service policy on segregation and adjudications, a risk assessment is now conducted before a prisoner is placed in cellular confinement
- There is a dedicated mental health nurse for the segregation unit at Manchester prison. This accords with good practice as recommended by the clinical adviser to the inquiry.
- Medical records are held electronically and accessible by authorised clinical staff from terminals, though not yet in the segregation unit.
- Manchester prison operates the ACCT arrangements which are a significant advance on the F2052SH system. The local policy includes, in particular, a Friends and Family Helpline, systems for responding to concerns about a prisoners, and questionnaires to prisoners after an ACCT plan is closed.
- The wing based disciplinary system was abolished in October 1999.
- Full statements of the circumstances are required and reviewed by managers whenever staff restrain a prisoner by force.

Recommendation

22.35 <u>I recommend that</u>

- the Governor of Manchester and his colleagues:
  - examine each stage of the process of vetting Samaritan volunteers and selecting Listeners to identify and eliminate any avoidable delays
  - ensure that Listeners can be made available in all locations at any time of day or night
  - make provision for prisoners to use the Samaritans telephone in private.

PART FOUR

FINDINGS, RECOMMENDATIONS AND OBSERVATIONS ABOUT INQUIRY PROCEDURE

Findings are based on the balance of probabilities but, in weighing the evidence, I have also had regard to the principle that the more serious the allegation is, the more cogent must be the evidence to prove it.

I have made some recommendations but have exercised restraint in doing so. Those who work in prisons are often best placed to draw lessons from past events and to devise operational solutions to deficiencies. I hope that the Prison Service and those who are responsible for healthcare in prisons will consider the findings and decide for themselves whether there are further lessons to be drawn.

LIST OF FINDINGS

Clinical care

1 Clinical care for Sonny Lodge's physical health was appropriate and consistent with practice at the time (paragraph 12.33).

2 Clinical record-keeping was generally good except for an apparent practice of recording on medication charts only when patients did not receive medication and not when they did. That is not reliable or satisfactory (paragraph 12.33).

3 The Prison Service did not deliver the psychiatric reassessment, counselling and support to stay off drugs which doctors advised that Sonny Lodge needed (paragraph 12.33).

Sonny Lodge's mental health

4 There is no evidence that Sonny Lodge's feelings of victimisation were the consequence of any psychotic illness (paragraph 12.33).

5 A sense of victimisation in the prison environment could have left Mr Lodge feeling increasingly powerless and hopeless, as reflected in his letters, and ultimately such feelings could have contributed to a state of mental ill-health and a desire to end his life (paragraph 12.33).

Assessing fitness

6 There was a systemic failure in the assessment of fitness for adjudication and cellular confinement in that it was made without reference to any history or prior knowledge of Sonny Lodge. That was not contrary to Prison Service policies in 1998 but it was unsatisfactory. Current Prison Service policy requires a risk assessment, including reference to medical records, before a punishment of cellular confinement is imposed. (paragraph 13.24).

Safeguards against suicide and self-harm

7 There was a systemic failure to protect Sonny Lodge in the last days of his life in that:

- Insufficient regard was paid to Ms A's warnings.
- Judgments were made not to open an F2052SH, in ignorance of material facts that ought to have been known.

- Information was not always recorded so that it was available to others.
- Where information was available, in the Inmate Medical Record, the escort records, the observation book and the history sheets, it was either not referred to when, reasonably, it should have been, or it was not taken into account, when it ought to have prompted special protection (paragraph 15.24).

8 If information had been shared properly, an F2052SH would have been opened. This would have altered the course of events and would probably have prevented Sonny Lodge taking his life when he did (paragraph 15.24).

9 The current arrangements for safeguarding prisoners against suicide and self harm represent a significant advance on the F2052SH system. I note in particular: the care planning approach, the emphasis on interaction, not observation, and on identifying and responding to specific individual need; the tapering of special support after a plan is closed; the requirement that concerns expressed by people outside the prison are systematically assessed (paragraph 15.24).

10 The best defence against suicide in prison is a positive prison culture which values prisoners as complex individuals, pays heed to the concerns of prisoners' family and friends, offers practical support with prisoners' problems and recognises that what a prisoner says to a stranger is not a sufficient way of assessing prisoners' distress (paragraph 15.24).

The incident at Whiston Hospital

11 At the time of the incident at Whiston Hospital, there was in existence a rumour that Officer Brownley would engineer an assault by a prisoner and Governor Williams spoke to Officer Brownley about it (paragraph 16.8).

12 At the time of the incident at Whiston Hospital, Officer Brownley had a pending appeal against refusal of an application for a transfer to Manchester prison (paragraph 16.8).

13 Despite these findings, there is insufficient evidence to conclude, on the balance of probabilities, that the incident in the toilet cubicle was premeditated or contrived (paragraph 16.8).

14 Sonny Lodge's behaviour in the waiting area at Whiston hospital was truculent and challenging (paragraph 16.8).

15 Officer Brownley's determination to enforce instant compliance with the hospital 'no smoking' policy was overzealous and he sought to enforce his instruction without the skill and sensitivity that could reasonably be expected of a professional officer (paragraph 16.8).

16 The inquiry finds on the balance of probabilities that Mr Lodge pushed Officer Brownley away in reaction to the officer's unjustified and inappropriate movement towards him (paragraph 16.8).

17 The inquiry is unable to conclude from the evidence available whether or not Officer Brownley laid hands on Mr Lodge before he was pushed (paragraph 16.8).

The Prison Service's response to the incident at Whiston Hospital

18 Notwithstanding the police investigation, prison managers should have ensured that use of force records were completed and, as a matter of routine, that an incident involving the use of force was investigated (paragraph 16.20).

19 The information about Officer Brownley's past disciplinary offence and the rumour circulating in the prison were material considerations that the prison ought to have disclosed to the police investigating Officer Brownley's complaint that Sonny Lodge assaulted him (paragraph 16.20).

Transfers, wing and cell moves and the wing based disciplinary system

20 The punishment imposed at the adjudication increased Sonny Lodge's vulnerability through confinement without means of occupation or distraction (paragraph 17.20).

21 To go back on the decision to return Sonny Lodge to E wing after the seven days' punishment was either a mistake or it was a deliberate decision for which reasons should have been recorded (paragraph 17.20).

22 The regime on K wing was unsatisfactory. It increased Sonny Lodge's alienation and distress (paragraph 17.20).

23 The wing-based disciplinary system gave unfettered authority to individual officers to impose penalties without due process that reduced prisoners'

opportunities for social interaction and supportive contact with families. It was unfair and may have been unlawful. It stopped in October 1999 (paragraph 17.20).

24 Loss of association under the wing-based disciplinary system increased Sonny Lodge's isolation and so may have increased his vulnerability (paragraph 17.20).

Was Sonny Lodge victimised?

25 Some prison officers may have spoken to Sonny Lodge about the incident at Whiston Hospital but I have found no evidence of prison officers conspiring to victimise him because of it (paragraph 18.21).

26 Repeated loss of association through the unfair wing-based disciplinary system increased Sonny Lodge's isolation, from support inside the prison and through family contact, and his alienation from prison staff. This may have contributed to deterioration in his behaviour, evoking increasingly authoritarian responses from staff (paragraph 18.21).

27 Sonny Lodge's sense of victimisation may have been exaggerated but it was not without foundation. It had a harmful effect on his state of mind (paragraph 18.21).

The search and the incident in the cell

28 The loss of association imposed by Officer Downs was not properly authorised and was not recorded in the restriction of facilities record as required (paragraph 20.9).

29 Sonny Lodge was the principal target of the search but there is no evidence to show that his cellmate was deliberately excluded from the cell or from the search for any malicious motive (paragraph 20.9).

30 It was legitimate to search cells more than once in a searching cycle and Officers Bowcock and Downs had authority to select Sonny Lodge's cell for an excess search that evening (paragraph 20.9).

31 There were entries in Sonny Lodge's record suggesting that he had previously handled unauthorised articles. Setting aside the rough justice of the wing-based disciplinary system, this gave some grounds for selecting him for a search (paragraph 20.9).

32 I attach no weight to the discrepancy between the searching officers and the senior officer about whether they identified the prisoner and cell they intended to search, but searches can be used punitively and legitimate searches can give rise to the appearance of unfair treatment. Wing managers should exercise active supervision over the selection of cells for searching (paragraph 20.9).

33. When asked to justify the search at the adjudication and to the police and when explaining why he did not complete the record, Officer Bowcock showed a casual disregard for his obligation to give evidence with care and accurately (paragraph 20.9).

34 I do not find that the search was a consciously vindictive act by the officers but, in taking note only of the negative entries in his history sheets, and in failing to notice the scars on his arms, they showed indifference to how Sonny Lodge might view the search as an additional sanction and indifference to his welfare (paragraph 20.9).

35 The way that Officer Bowcock drew Sonny Lodge's attention to the rules was provocative and unprofessional (paragraph 20.9).

36 There is insufficient evidence to conclude whether the gestures of Officer Bowcock or Sonny Lodge were the more threatening (paragraph 20.9).

37 There is insufficient evidence to determine whether the use of force on Sonny Lodge was justified and lawful (paragraph 20.9).

38 An adjudication about a related charge against a prisoner is not a sufficient investigation of the use of force. Prison managers should have ensured that use of force records were completed and, as a matter of routine, that an incident involving uses of force was investigated (paragraph 20.9).

The adjudication and punishment

39 Governor McColm acted in good faith. He had no knowledge of Sonny Lodge's history of self-harm or the concerns expressed by his girlfriend that week (paragraph 21.16).

40 Governor McColm's decision to segregate Sonny Lodge was based on an evaluation of where he would receive the best care, but cellular confinement is punishment and isolation may increase vulnerability (paragraph 21.16).

41 Governor McColm did not explore the circumstances of the incident sufficiently to dispose of Sonny Lodge's counter-allegation against Officer Bowcock (paragraph 21.16).

42 Governor McColm did not explore the circumstances of the incident sufficiently to find that the charge against Sonny Lodge was proved beyond reasonable doubt (paragraph 21.16).

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43 The assessment of Sonny Lodge's fitness for adjudication and cellular confinement before the hearing complied with Prison Service policy at the time but the system of assessing fitness without regard to any history or prior knowledge was not satisfactory. Current Prison Service policy now requires a risk assessment, including reference to medical records, before a punishment of cellular confinement is imposed (paragraph 21.16).

44 After 4.40 in the afternoon on 28 August, when Sonny Lodge was in segregation, he was not observed at least once an hour as required by the Prison Discipline Manual (paragraph 21.16).

Communications and record-keeping

45 Use of Force and Injury to Inmate forms should have been completed on two occasions and were not (paragraph 22.17).

46 On 27 August, loss of association and search records were not completed in accordance with the required procedures (paragraph 22.17).

47 Information was not always recorded so that it was available to others. Where information was available in the IMR, the escort records and the history sheets it was either not referred to when, reasonably, it should have been, or it was not taken into account, when, reasonably it ought to have prompted special protection. Consequently, judgments were made not to open an F2052SH in ignorance of material facts that ought to have been known (paragraph 22.18).

What has changed at HMP Manchester

48 From evidence given to the inquiry, I note the following significant changes in arrangements at Manchester relating to specific problems identified in this report:

- In accordance with Prison Service policy on segregation and adjudications, a risk assessment is now conducted before a prisoner is placed in cellular confinement
- There is a dedicated mental health nurse for the segregation unit at Manchester prison. This accords with good practice as recommended by the clinical adviser to the inquiry.
- Medical records are held electronically and accessible by authorised clinical staff from terminals, though not yet in the segregation unit.
- Manchester prison operates the ACCT arrangements which are a significant advance on the F2052SH system. The local policy includes, in particular, a Friends and Family Helpline, systems for responding to concerns about a prisoners, and questionnaires to prisoners after an ACCT plan is closed.
- The wing based disciplinary system was abolished in October 1999.
- Full statements of the circumstances are required and reviewed by managers whenever staff restrain a prisoner by force (paragraph 23.34).

LIST OF RECOMMENDATIONS

I have exercised restraint in making recommendations. Those who work in prisons are often best placed to draw lessons from past events and to devise operational solutions to deficiencies. I hope that the Prison Service and those who are responsible for healthcare in prisons will consider the findings of this inquiry and decide for themselves whether there are further lessons to be drawn.

Mental health care in segregation units

1 I recommend that the Prison Service urges all prisons, in conjunction with their local primary care trust, to provide dedicated mental health care for segregation units (paragraph 13.25).

Access to Electronic Medical Information System (EMIS) in segregation units

2 I recommend that Electronic Medical Information Systems (EMIS) in prisons incorporate provision for clinical staff to have confidential access to medical information at a terminal in the segregation unit (paragraph 13.25).

Disclosure of information to the police

3 I recommend that the Prison Service considers issuing further guidance on disclosure in cases where the police are investigating allegations of assault involving prisoners and prison staff (paragraph 16.21).

4 In particular, I recommend that where the Prison Service declines to investigate possible misconduct by staff because of a related police investigation, there is a presumption that information that would have been material to a conduct investigation should be disclosed to the police (paragraph 16.21).

Circulation of reports

5 I recommend that the Prison Service ensures that reports into the circumstances of a death in prison are brought to the attention of all the establishments mentioned in the report's findings or conclusions so that any appropriate action can be taken and any lessons learned (paragraph 16.21).

Adjudications and use of force

6 I recommend that the Prison Service advises adjudicators to consider examining use of force statements in any adjudication where force has been used following an incident of alleged assault (paragraph 21.17).

Communications and record-keeping

7 I recommend that the Prison Service considers whether specific guidance might usefully be issued on the appropriate use of prisoners' history sheets, in particular so that:

- information affecting a prisoner's custody and care is reliably recorded in his or her personal record; and
- it is referred to when prisoners change locations or other significant events occur (paragraph 22.19).

8 I recommend that the Prison Service considers issuing specific guidance about recording information received from family, friends or outside agencies that a prisoner may be at risk of suicide or self-harm (paragraph 22.19)

Manchester prison

9 I recommend that the Governor of Manchester and his colleagues:

- examine each stage of the process of vetting Samaritan volunteers and selecting Listeners to identify and eliminate any avoidable delays;
- ensure that Listeners can be made available in all locations at any time of day or night; and
- make provision for prisoners to use the Samaritans telephone in private (paragraph 23.35).

LIST OF OBSERVATIONS ABOUT INQUIRY PROCEDURE (PARAGRAPH 2.40)

Procedure observation 1:

Status of the investigation

The need to compel a key witness to give evidence caused additional delay and expense. Those who conduct similar inquiries in future may wish to seek conversion to a statutory inquiry at an early stage if there are indications of a lack of cooperation from witnesses such that compulsive powers may be required.

Procedure observation 2:

Inquiry procedures

The Inquiries Act 2005 and the inquiry Rules 2006 provide a helpful guide to procedures that are fair to all parties. Those who conduct similar investigations in future may find it helpful to refer to them in devising procedures. Where there is a possibility that an investigation may be converted to a statutory inquiry, it may be particularly helpful to have regard to the Act and the Rules in order to avoid any conflict between the procedures applying to the non-statutory stage and those that apply in the event of conversion.

Procedure observation 3:

The bereaved family

In inquiries of this kind it may be appropriate for the bereaved family to be offered an opportunity to speak briefly in person as part of the closing procedures immediately before the final legal submissions, provided that it is understood that new allegations and evidence cannot be introduced at that stage.

ANNEXES

ANNEX 1

TERMS OF REFERENCE[1]

1. To enquire into the circumstances surrounding the death of Bernard (Sonny) Lodge at HMP Manchester on 28 August 1998 in accordance with Article 2 of the ECHR drawing on

   - evidence gathered in the Prison Service investigation
   - additional documentary and oral evidence at the discretion of the Investigation Chair,

   and to take into account the issues identified by the Investigation Chair's Provisional List of issues attached to these terms of reference and dated 3 December 2007.

2. The purpose of the Investigation is:

   to examine the care afforded to Mr Lodge by the Prison Service in the period leading to his death, in order to identify any deficiencies that may have had an influence on his death and to help prevent such tragedies in future.

3. The Investigation should seek to engage Mr Lodge's family members as participants in the Investigation.

4. The Chair may make recommendations to the Director of High Security Prisons in her report in respect of the Investigation's findings, which may include issues relating to procedures or the conduct of individuals that the Chair considers ought to be included.

5. A draft Investigation Report will be made available to the Director of High Security Prisons in the Prison Service and the representatives for Mr Lodge's family so that any factual inaccuracies may be addressed before final publication.

6. The Investigation Report is to be presented to the Director of High Security Prisons in the Prison Service. The report will be provided to Mr Lodge's family and become a public document.

7 The investigation should address in its written procedures appropriate arrangements for the handling of sensitive information such as (but not limited to) identification of vulnerable prisoners or intelligence sources.

[1] The terms of reference and the procedure were adopted before the investigation was converted to a statutory inquiry. The inquiry departed from them where required to do so to comply with the Inquiries Act 2005 and the Inquiry Rules 2006.

PROVISIONAL LIST OF ISSUES FOR FURTHER EXAMINATION

1. **Medical care**

   To examine whether the medical care of BL was appropriate including the assessment that BL was fit for adjudication and cellular confinement on 28 August 1998.

2. **Safeguards against suicide and self-harm**

   To examine whether the F2052SH procedure was operated in accordance with Prison Service guidance and whether there are lessons to be drawn about caring for prisoners at risk of self-harm and/or suicide. In particular, to examine the response to information from a day centre manager and BL's girlfriend, the knowledge that he had been refused bail, and observations that he was distressed during the adjudication.

3. **The incident at Whiston Hospital**

   To examine the circumstances of the incident at Whiston Hospital which led to BL not being released on 28 August. In particular, to examine whether the Prison Service acted or ought to have acted on concerns expressed by a governor at HMP Garth and the Prison Service investigation.

4. **Transfers, wing and cell moves**

   To examine the reasons that BL was frequently moved, the regimes he experienced and whether these may have contributed to his vulnerability to suicide and/or self-harm.

5. **The 'minor reports' system**

   To examine the impact of the 'minor reports' disciplinary system on BL and whether this may have contributed to his vulnerability to suicide and/or self-harm.

6. **The search, the incident in the cell, the transfer to the segregation unit**

   To examine conflicts in the evidence about the reasons for the search, the justification and conduct of it, the incident in the cell and whether these events may have contributed to BL's vulnerability

7. **The adjudication**

   To examine whether the conduct and conclusion of the adjudication was in accordance with Prison Service guidance.

8. **Was Sonny Lodge victimised?**

   To examine whether there were grounds for BL's belief that he was being victimised as a result of the incident at Whiston Hospital or for other reasons and what role, if any, this played in the circumstances of his death.

9. **Communications and record-keeping**

To examine deficiencies identified by the Prison Service investigation in communications and record-keeping and what role, if any, this played in the circumstances of BL's death.

10. **What has changed at Manchester prison?**

To examine how the care of prisoners at risk of suicide and/or self-harm has changed at Manchester prison since BL's death, in particular, in matters in which the Prison Service Investigation into BL's death identified deficiencies.

03 December 2007

ANNEX 2

INDEPENDENT INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF BERNARD LODGE

DOCUMENT IP1 - PROCEDURES[1]

1. The investigation is commissioned by the Director of High Security Prisons to enquire into the circumstances surrounding the death of Bernard (Sonny) Lodge at HMP Manchester on 28 August 1998. Full terms of reference are attached (Annex 1).

2. The Chair of the investigation is Ms Barbara Stow, who will have sole responsibility for the report.

3. This document sets out the procedures that the investigation has decided to adopt.

Contact details

4. The solicitor to the investigation is Mr Christopher Topping, Jackson and Canter, Solicitors, 88 Church Street, Liverpool, L1 3HD (Telephone: 0151 282 1700). This is the correspondence address for the investigation.

5. The solicitor to the investigation may be contacted by e-mail at ctopping@jacksoncanter.co.uk. The Chair of the investigation may be contacted by e-mail at lodgeinquiry@btinternet.com.

6. The investigation will be announced by press release and on a website.

Interested parties

7. The interested parties identified so far are Mr Lodge's sisters, represented by Mr Robert Lizar, solicitor, and Mr Pete Weatherby, Counsel, and the Ministry of Justice, represented by the Treasury Solicitor, Ms Alex Forgaard, and Counsel, Mr Nick Moss. Anyone else who wishes to be treated as an interested party should apply to the Chair through the solicitor to the investigation. Each application will be considered and determined by the Chair.

Preliminary evidence gathering

8. The investigation has examined the evidence obtained for the Prison Service Investigation and a disciplinary investigation, written statements made to the inquest and a summary note of oral evidence, and other documentary evidence provided by the interested parties. A chronology of evidence based on that material has been supplied as a working tool for the interested parties and may be made available in whole or in part to other witnesses to whom it may be

[1] The terms of reference and the procedure were adopted before the investigation was converted to a statutory inquiry. The inquiry departed from them where required to do so to comply with the Inquiries Act 2005 and the Inquiry Rules 2006.

helpful. The chronology will not form part of the final report but users are asked to tell the solicitor to the investigation about any errors or omissions.

9. These documents form core bundles 1 to 3 which have been supplied to the interested parties.

10. The investigation requests parties and anyone who holds documents which they consider are relevant to its work to supply those documents to the Solicitor to the investigation. The investigation may request further documents from the parties or other persons whom it considers hold relevant material.

11. The investigation will distribute to the interested parties in the form of additional bundle(s) copies of such additional documentary evidence as may be obtained in the course of the investigation.

12. Particular documents may be provided to persons and bodies who are not interested parties if appropriate.

Sharing of information provided to the investigation

13. This is an Article 2-compliant investigation and it will be conducted in an open and transparent manner. The investigation will normally assume that all the material it receives may be distributed to the interested parties and referred to at the investigation's hearings.

14. Where a person considers that any part of a document, transcript, statement or other material should not be treated in this way, he or she should inform the solicitor to the investigation of the reasons for this view when the document or statement is provided. The investigation will consider each such representation on its merits and deal with it as it considers appropriate.

List of issues

15. Drawing on the preliminary evidence-gathering and submissions by the interested parties, the investigation has drawn up a list of issues for further examination. These are incorporated in the terms of reference. Additional issues may be added in the course of the investigation.

Clinical Review

16. The investigation will commission a clinical review from an appropriate independent practitioner.

Witnesses

17. The investigation has identified a provisional list of persons who will be asked to provide a written statement in reply to specific questions and a further list of people to be notified of the investigation and invited to contribute if they can add significant information to their previous evidence.

18. All the persons approached will be directed to the issues about which it is considered they may have relevant evidence. They will be supplied with copies of

such of their own previous statements as the investigation possesses, and documents that are relevant. They will be told that they may be asked to give oral evidence.

19. The Chair will visit Manchester prison and write to the persons identified shortly afterwards. A notice about the investigation and the Chair's visit will be distributed to staff and prisoners at Manchester prison.

20. If the Chair's visit or notice of the investigation elicits further relevant witnesses or lines of investigation these will be added.

21. Witnesses will be asked to return written statements within six weeks of the investigation's request. The investigation will copy statements to the interested parties.

Oral evidence

22. The investigation may ask a person who has provided a written statement or other persons to appear before the investigation and give oral evidence in public. Oral evidence from witnesses will only be required for one or more of the following purposes:

    (a) to clarify and amplify matters in the statement in respect of which further information is required to assist the investigation.

    (b) to assist the Investigation by giving the witness the opportunity of addressing matters raised by other statements or documents or the oral evidence of other witnesses and to test the accuracy of matters upon which evidence is given.

    (c) to deal with any other matter which the investigation considers appropriate.

23. A person asked to give oral evidence may apply to be represented during his or her evidence.

Pre-hearing meeting

24. Not less than 10 weeks after requests for written statements are issued and not less than 12 weeks before oral hearings, the investigation will meet the interested parties, in private, to discuss the conduct of the hearings, which witnesses should be called, lines of questioning and any other relevant matters.

25. Any party who wishes to make submissions about oral evidence, lines of questioning or other matters must do so in writing to the Solicitor to the investigation at least one week in advance of the preliminary meeting.

26. The issue of which witnesses are to be called to the public hearing will then be dealt with at the preliminary meeting by the Chair and her decision will be final.

Notice of matters requiring explanation

27. Before any person is requested to give oral evidence at the investigation's hearings, he or she will normally be sent a letter setting out the main issues that the investigation intends to address in the course of questioning. The issues set out should not be treated as a definitive list as further issues may emerge about which the witness may be able to provide relevant evidence. The letter is designed to assist the witness (and his or her representative|) in preparing for the investigation's hearings by identifying at least some of the matters about which the investigation is particularly concerned.

28. As far as it is possible to do so, the investigation will endeavour to provide witnesses asked to give oral evidence with a list of the main documents to which questions are likely to refer.

29. In some cases the letter may also include a list of matters in respect of which the solicitor to the investigation considers it possible that the witness might be subject to criticism. Each witness will be given the opportunity to address each potential criticism during the course of his or her oral evidence. It should be emphasised that the matters listed in this way will have been identified during the preliminary review of documents and in no way represent the settled view of the Chair.

Conduct of hearings

30. The investigation will open the public sessions with a statement first about the history, purpose and procedure of the investigation, followed by a narrative summary of facts as indicated by the evidence so far, and a statement of the issues the investigation will examine. The interested parties will be invited to make brief opening statements within a timetable to be decided by the Chair. The interested parties are asked to provide opening statements in writing to the investigation not less than one week before the hearing. Statements will be copied to interested parties.

31. Any person requested to give oral evidence will be questioned by the solicitor to the investigation and/or by the Chair. Before dismissing a witness, the Chair will ask the interested parties whether there are any further matters that the witnesses should be asked to address. If the Chair is satisfied that further questions should be asked, the solicitor to the investigation or the Chair will put them to the witness.

32. Once the evidence at the investigation's hearings has been concluded, the Chair will invite the interested parties to submit closing statements in writing and offer the opportunity for closing oral statements.

Draft report

33. A draft investigation report will be made available in confidence to the Director of High Security Prisons and the representatives of Mr Lodge's family so that any factual inaccuracies may be addressed before final publication.

34. Relevant extracts from the draft report will be sent in confidence to witnesses (and any other identifiable persons who may be mentioned adversely in the report) for identification of errors or omissions and any comment. Any witness or other identifiable person who may be mentioned adversely will be told of relevant probable findings so that they may comment if they wish before final publication. The investigation may send the draft or extracts in confidence for comment to other persons who are not mentioned adversely.

35. The draft will take due account of any applications made in respect of sensitive information (such as the identification of vulnerable prisoners or intelligence sources) that may require redaction.

Final report

36. The Investigation Report will be presented to the Director of High Security Prisons in the Prison Service. The report will be both provided to Mr Lodge's family and become a public document, subject always to any applications that are made in respect of sensitive information (such as identification of vulnerable prisoners or intelligence sources) that may require redaction.

Barbara Stow
6 February 2008

ANNEX 3

LIST OF LEGAL REPRESENTATIVES

Solicitor to the inquiry

Mr Chris Topping of Jackson and Canter, Solicitors

For Ms Sylvia O'Reilly, Mr Lodge's sister

Mr Pete Weatherby, Garden Court North

instructed by

Mr Robert Lizar of Robert Lizar, Solicitors

For the Ministry of Justice

Mr Nicholas Moss, 1 Temple Gardens

instructed by

Ms Alexandra Forgaard, Treasury Solicitor

For the Prison Officers' Association

Mr Henry Mainwaring, Phoenix Chambers

instructed by

Mr Keith Sheppard, formerly of Lees, Lloyd Whitley, Solicitors, later of Thompsons, Solicitors

ANNEX 4

ACRONYMS AND REFERENCES

ACCT	Assessment, Care in Custody and Teamwork. This is the name of the current Prison Service policy to protect prisoners against suicide and self-harm.
AG	Advice to Governors
F2052A	Record of Events. Part of an individual prisoner's record. Commonly known as 'history sheets'. It is held on the residential unit where the prisoner is based.
F2052SH	Self harm at risk form
F213	Injury to Inmate record form
HMP	Her Majesty's Prison
HMCIP	Her Majesty's Chief Inspector of Prisons
HMCIP 1996	*HMP Manchester: Report of a Full Announced Inspection by HM Chief Inspector of Prisons,* Home Office, London
HMCIP 1998	*HMP Manchester: Report of an Unannounced Short Inspection,* Home Office, London
HMCIP 2002	*Report on a Full Announced Inspection of HM Prison Manchester 11-21 November 2001 by HM Chief inspector of Prisons*
IEP(S)	Incentives and Earned Privileges (Scheme)
IG	Instruction to Governors
IG 1/1994	Caring for the Suicidal in Custody
IG 79/1994	Caring for the Suicidal in Custody (additional guidance)
IMR	Inmate Medical Record
PDM 1995	The Prison Discipline Manual that was issued in 1995. It was replaced in 2006 by PSO 2000 (see below), in force from January 2006
PO	Principal Officer

PSI	Prison Service Instruction
PSI 18/2005	Introducing Assessment, Care in Custody and teamwork – the replacement for the F2052SH
PSO	Prison Service Order
PSO 1700	Prison Service Order on Segregation
PSO 2000	Prison Service Order on Adjudications
PSO 2700	Suicide Prevention and Self-Harm Prevention (2002 edition)
	Suicide Prevention and Self Harm Management (2007 edition)
PSO 4000	Prison Service Order on Incentives and Earned Privileges Scheme
RMN	Registered Mental Health Nurse
SO	Senior Officer
Standing Order 4	Prison Service Standing Order on Facilities

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